A thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy

RESPONDING TO THE HEALTH NEEDS OF INTERNALLY DISPLACED PERSONS: AN ANALYSIS OF THE INDONESIAN HEALTH SYSTEM

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Abstract

Since 1998, several provinces in Indonesia have suffered a number of violent conflicts causing massive destruction, several thousand deaths and creating over a million displaced people. This happened in North Maluku and Central Kalimantan Provinces. In 1999 the displaced people from North Maluku took flight to Manado municipality and in 2001 those from Central Kalimantan fled to Sampang District. These recipient areas were selected for this study because of their differing characteristics, including presence of IDPs; urban/rural; and levels of development.

While the central government was initially responsible for providing adequate support in the first two -three years of their displacement in both areas, this changed at the end of 2003 when the central government terminated their support for the IDPs. During this period, authority for developing health programmes and services had been devolved to local government by central government through the health decentralisation policy in 2001, which created additional challenges to their meeting the needs of the incoming IDP population and particularly after the removal of government support for IDPs in 2003.

This research was designed to contribute to a policy or model to be developed by the Indonesian health authorities to provide services for IDPs. The research questions were: what are the key health needs of the displaced population in the two selected recipient areas in Indonesia; what are the problems experienced by services in the municipality and district in seeking to meet these needs; to what extent has the public sector identified and responded to the health needs of the IDPs in the context of the health decentralisation policy that was currently being implemented in these two areas; on the basis of the preceding analysis, what are appropriate recommendations for the provision of health services to the displaced populations of Indonesia?

The research employed mixed methods in handling the above questions. It was conducted through direct observation, surveys and focus group discussions (FGD) with IDPs. Semi-structured interviews were conducted with the Heads of the Municipal/District Health Offices and Heads of selected *puskesmas* in the recipient IDP areas. Respondents for surveys were selected by using a formula for estimating statistical proportions. 71 respondents in Manado and 116 respondents in Sampang were selected and respondents for FGD were selected through purposive sampling.

This thesis presents the effect of the reception of IDPs on the local health systems and the responses of the areas that received them. It argues that IDPs, trapped in complex emergency situations with consequent increased health needs, added a burden to the health systems in the recipient areas

The findings indicated that the local health authorities were unable to fully meet the health needs of the IDPs and therefore suggested that local health systems need to be improved at the same time as the implementation of the health decentralisation policy.

This thesis provides recommendations for the public health sector capacity in the areas that received the IDPs. These are intended to enable the national health system to fill the gap between the health needs of the IDPs and the local authority health system.
Recommendations include: redefinition of functions of local health institutions, ensuring a better quality of health service and strengthening the referral system.

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Abbreviations

ABRI	*Angkatan Bersenjata Republik Indonesia*
ANC	Antenatal Care
ASKES	*Asuransi Kesehatan* (Health Insurance)
Bakornas-PBP	*Badan Koordinasi Nasional Penanggulangan Bencana dan Penanganan Pengungsi*
BPS	*Biro Pusat Statistik*
CAI	Creative Associates International
CERTI	Complex Emergency Response and Transition Initiative
CHSM	Centre for Health Service Management
CWS	Church World Service
DAK	*Dana Alokasi Khusus*
DAU	*Dana Alokasi Umum*
DBH	*Dana Bagi Hasil*
DHO	District Health Office
df	degree of freedom
EPI	Expanded Programme on Immunisation
FC	Foundation Coalition
FGD	Focus Group Discussion
GMU	*Gajah Mada* University
HAD	Health Development Agency
HIV/AIDS	Human Imuno Virus/Acquired Immune Deficiency Syndrome
HPCR	Humanitarian Policy and Conflict Research
iDMC	internal Displacement Monitoring Centre
IDP	Internally Displaced Person
ITHPH	Institute for Tropical Hygiene and Public Health
JICA	Japan International Cooperation Agency
JPKM	*Jaminan Pemeliharaan Kesehatan Masyarakat*
MoH	Ministry of Health
MHO	Municipality Health Office
MoPH RoY	Ministry of Public Health Republic of Yemen
MSS	Minimum Standard Service
MCH	Maternal Child Health
NGO	Non-Government Organisation
PAD	*Pendapatan Asli Daerah*
PHAC	Public Health Agency of Canada
PKI	*Partai Komunis Indonesia*
PNC	Postnatal Care
TBA	Traditional Birth Attendance
RI	Republic of Indonesia
Satkorlak PBP	*Satuan Koordinasi Pelaksana Penanggulangan Bencana dan Pengungsi*

Satlak	*Satuan Pelaksana*
SCONA	Student Conference On National Affair
SIDA	Swedish International Development Agency
SDC	Swiss Development for Corporation
SINTEF	Scientific and Industrial Research at the Norwegian Institute of Technology
UN	United Nations
UN OCHA	United Nations Office for the Coordination of Humanitarian Affairs
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
UNICEF	United Nations Children's Fund
WFP	World Food Program
WHO	World Health Organization
WHO CSS	World Health Organization Country Cooperation Strategy
WHO SEARO	World Health Organization South East Asia Regional Office

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Introduction

1. Background

Indonesia has experienced political conflict and ethnic violence in several regions of the country since 1999. Serious conflict and consequent population displacement has occurred in several provinces, exacerbated by Indonesia's political and economic crisis.

There have been two main types of conflict in Indonesia: communal conflict, where the central dynamic is competition between regional elites over access to political and economic power using their ethnic and religious background; and nationalist secessionists, where the population of particular territories reject state authority and control. In the first category are West and Central Kalimantan, Central Sulawesi, and North Maluku and Maluku provinces. Aceh and Papua provinces fall into the second category (Morris, 2002). These conflicts have been responsible for thousands of deaths in the past few years and created many Internally Displaced Persons (IDPs).

An economic crisis due to a collapse in the value of the Indonesia *rupiah*, and the lifting of the social and political order associated with the fall of Suharto in May 1998 coincided with increasing divisions within Indonesian society on ethnic, religious, political and social grounds. Brussets and colleagues revealed that "migration and, especially, transmigration programme are inherently linked to instability and subsequent displacement in Indonesia. The transmigration programme in the New Order • aimed to reduce demographic imbalance in the country, especially between Java and other islands. Apart from some success stories, the programme also generated new risks especially in its lack of sensitivity to the issue of ethnic imbalance and to land disputes and natural resources" (Brussets *et al.*, 2004; 66).

• The New Order (in *Bahasa* Indonesia *Orde Baru*) is the term coined by the former Indonesian President Suharto to characterise his regime when he came to power in 1966. Suharto used this term to contrast his rule with that of his predecessor, Sukarno (dubbed dismissively as the "Old Order," or *Orde Lama*). The term "New Order" in more recent times has became synonymous with the Suharto years (1966-1998).

Currently the IDPs are a persisting element in Indonesian society, bringing new challenges to the public sectors. This is particularly so in the health sector, due to the magnitude and complexity of IDPs' circumstances. In 2002 about 1.4 million people became IDPs in Indonesia, having been forced to flee their homes and reside in other safer places. According to *Bakornas-PBP* (Indonesian National Coordinating Agency for Natural Disaster and Refugees Relief) and UN-OCHA, over the evaluation period the number of IDPs caused by complex emergencies gradually dropped to 586,769 in 2003 (*Bakornas PBP* and UNOCHA, 2003), and the IDP emergency was declared officially over by the Government at the end of 2003 (iDMC, 2006a). However, in 2004 a total of 342,000 people were still displaced (ibid). Rather than return to their homelands some IDPs decided to settle in the recipient areas and seek employment.

During this period of crisis, the government became more responsive in acknowledging their primary responsibility for protecting and assisting the affected populations under their control. Unfortunately, the public health institutions that provided services to the IDPs had no experience of developing health policies, health programmes and providing health services for a large number of people arriving simultaneously and deciding to live in their area. The situation was made even more complex by the health decentralisation policy that was instituted in 2001.

At present Indonesia is one of the more decentralised nations in the world. The regions are responsible for one-third of all government spending, and half of the development budget. In May 1999, the Indonesian parliament passed Law No. 22 (1999) on Regional Governance and Law No. 25 (1999) on Fiscal Balance between the Central Government and the Regions in conjunction with the decentralisation policy. In 2001, in order to respond to the commitment of the decentralisation policy, the health authority in central level released the health decentralisation policy. In October 2004, the parliament passed amendments to the 1999 legislation to improve the status quo, but some fundamental changes are still needed before decentralisation can work effectively.

The impact of conflict in either the original conflict zones or the recipient areas posed an additional challenge to the process of health decentralisation.

Many studies on the situation of IDPs, particularly in relation to conflict have been undertaken, but few have dealt with the impact of complex emergencies on recipient areas from a health system perspective. A study of the availability of effective interventions to improve the health of IDPs in recipient areas undergoing a process of decentralisation has also not previously been undertaken. The specific research questions in this present research have not been addressed before.

2. Objectives of Research

The research focused on the health of IDPs who lived in the recipient areas and the response of the local health authorities in these areas to their needs.
The objectives of this research were:

- to investigate the perceived health status and prevalence of disease in displaced persons in selected areas of Indonesia.
- to identify the current nature and range of health provision for displaced persons provided at municipal/district level, identifying challenges in the context of the move towards health decentralisation.
- to analyse the data obtained from objectives number one and two in relation to the different models of health systems as discussed in the literature review.
- to contribute towards the development of a health policy for displaced persons in Indonesia.

This research does not claim to be a comprehensive study of the health needs of IDPs and the health system at municipal and district level. However, it represents an interpretation of the view given by specific respondents at the particular time they took part in the research. Also, the recommendations resulting from this research are not a prescription to eliminate the health problems of the IDPs in recipient areas, but focus on efforts to smooth the progress of health authorities in Indonesia in identifying and

eliminating constraints preventing health systems from providing good health service coverage for IDPs, while at the same time implementing the health decentralisation policy.

2.1 Significant Aims in Conducting This Research

This research aimed to make recommendations for the Indonesian health system to address the health needs of a displaced population, particularly in recipient municipalities and districts, within the context of increasing decentralisation.

Several factors point to the value of such research. Firstly, some parts of Indonesia are still unstable in terms of security and are prone to natural disasters which could create more IDPs. There is a need to provide recommendations to the public health sector in order to develop a policy or model for decentralised health at both central and local levels in areas that receive IDPs.

Secondly, there has been criticism from communities and Non Government Organisations (NGOs) that the Indonesian government's ability to respond to the needs of displaced persons has been inadequate.

Thirdly, there is evidence that government health programmes targeting this population have been costly, with overlap between services and have failed to achieve the expected results (Elmquist, 2001).

2.2 What This Research is Intended to Contribute

Since the beginning of 2001, the health authority at both central and local levels has had an increasing desire to improve health systems and policies, in conjunction with the health decentralisation policy, particularly regarding health programmes and services in the areas that received IDPs.

The lack of a clear policy and model for health programmes and services based on the health needs of the IDPs and on local characteristics, particularly in the areas that received them, has resulted in increasing the difficulties of the public health authorities in providing better services to the IDPs.

The recommendations of this research could contribute to a policy or model to be developed by the Indonesian health authority in order to fulfil the health needs of IDPs in the recipient areas. The methodology of the research and the recommendations could make a contribution to benefit not only the IDPs, but also assist in devising a health policy for all vulnerable people in Indonesia.

3. Research Questions

This research was intended to answer the following questions:

- What are the key health needs of the displaced population in two selected recipient areas in Indonesia, a municipality and a district?
- What are the problems experienced by services in the municipality and district in seeking to meet these needs?
- To what extent has the public sector identified and responded to the health needs of the IDPs in the context of the health decentralisation policy that was at the time of research being implemented in these two areas?
- On the basis of the preceding analysis, what are appropriate recommendations for the provision of health services to the displaced populations of Indonesia?

4. Thesis Overview

The thesis begins with background information on Indonesia and is followed by literature reviews of complex emergencies and their consequences, health needs, health systems and health decentralisation. Furthermore, the thesis explains the details of the research methodology, the findings, analysis and discussion, conclusions and recommendations.

Chapter One: Background Information and the History of Complex Emergencies in Indonesia

In this chapter background information on Indonesia describes the history of the country, its geography, religions, socioeconomic situation, politics, policies and government divisions, as well as its health development and the trend of health status.

It provides historical information on complex emergencies in Indonesia, the two areas that suffered from the complex emergencies and from which people were displaced; also on the two areas chosen for field work, including their geography and epidemiological profile.

Chapter Two: Complex Emergencies: Causation and Consequences to Health

In this chapter, complex emergencies caused by ethnic religious and political conflicts are analysed with the purpose of gaining a more detailed understanding of causes and consequences, particularly with regard to the affected population and health systems. The existing evidence within the literature review from countries that experienced complex emergencies brings a comprehensive understanding of how these emergencies have many consequences, not only in the areas that suffer the conflict but also in those that receive IDPs.

This chapter also highlights the impact on the existing health systems in the areas that received IDPs.

Chapter Three: Health Needs, Health Systems and Health Decentralisation Policy

This chapter examines current knowledge about health needs, health systems and health decentralisation policy through literature reviews. This literature review will contribute to and support the argument of this thesis in order to answer the research questions.

The chapter describes the health system that existed in Indonesia, in particular its organisational structure, and the role and functions of the health authorities from central to peripheral levels. It focuses on the municipal and district level health authorities and their interaction with the vertical and horizontal levels of their organisations.

The chapter also describes both the decentralisation policy of Indonesia and the health decentralisation policy by referring to the public health sector documents and other research, and includes main issues that became potential problems in the process of health decentralisation policy.

Chapter Four: Research Methodology

Details of the research methodology employed in the study are presented in this chapter. It discusses the epistemology; theoretical framework; conceptual framework of the research; methods used and the reasons for choosing the methods and their application; and the research process such as the sampling procedure and the analysis of the data.

Chapter Five: The Internally Displaced Persons: Health Needs and Experiences of the Public Health Sectors' Services in Manado Municipality and Sampang District

This chapter presents qualitative and quantitative data through parallel approaches and demonstrates the situation and characteristics of the IDPs' struggle with everyday life and their health status during their exile from their homelands. Themes, sub-themes and categories were developed from both qualitative and quantitative data and detail how the IDPs' determinants of health influenced their health while living in temporary accommodation and how they were able to access and utilise the essential health services offered by the public sector. It examines barriers to the IDPs' use of the health services and their level of satisfaction with the available health services in the areas where they lived. Descriptive statistics were presented by using quantitative data and interpret the numerical data gathered from the surveys.

Chapter Six: The Health System, and its Response to the Health Needs of IDPs and Health Decentralisation in Manado Municipality and Sampang District

This chapter describes the health systems in the two different fieldwork sites. It details how the Municipal Health Office (MHO) and District Health Office (DHO) dealt with the development of programmes and provision of services to the IDPs and the effect of the health decentralisation policy. Coordination between local government and related public sectors, coordination of Health Programmes with the PHO and MoH and with NGOs, the capacity of Health Resources and the local political situation are explored.

Chapter Seven: Discussion

This chapter brings together the findings of the research with the evidence of the health needs of the IDPs and the local authorities' response to them. This is followed by discussion and arguments regarding the findings of the research and their support in the literature.

Throughout the chapter, contrasts are made between the IDPs' health needs and the response of the existing health systems in the two field areas. The response of the public health sectors in providing health services to care for the physical and psychological health needs of the IDPs, in the period of the arrival of IDPs up to the time of the research is discussed. It indicates how the level of service had to be adjusted according to the progress of the health decentralisation policy.

Chapter Eight: Conclusions and Recommendations

The final chapter of this thesis presents conclusions drawn from the research findings. It includes recommendations for the Indonesian public health sector in order to improve health systems, particularly as applied to their displaced populations in the light of the process of health decentralisation. The needs and suggestions for further research are presented in this chapter.

Chapter One

Background Information and the History of Complex Emergencies in Indonesia

Introduction

This chapter outlines important aspects of Indonesia's geography, demography, religion, history and socio-economic situation. Also included are details of the country's government, politics, administrative divisions, health development and endeavours, and the trends its current health status. The complex emergencies that affected the country, particularly in the North Maluku and Central Kalimantan provinces are explained. Government, politics and administrative divisions are also elaborated**.**

The geographic, demographic and epidemiological profiles are provided for the recipient Internally Displaced Person (IDP) areas Manado Municipality, North Sulawesi Province and Sampang District, East Java Province which formed the field work sites for this study.

1.1 Geography, Population and Religion

Indonesia is a huge archipelagic country extending 5,120 kilometres from east to west and 1,760 kilometres from north to south. It encompasses 17,508 islands (some sources say as many as 18,000), of which only about 6,000 are inhabited. It lies on the crossroads between two oceans, the Pacific and the Indian, and bridges two continents, Asia and Australia. It straddles the equator and has a strategic location astride or along major sea-lanes from the Indian Ocean to the Pacific. Five main islands and about 30 smaller archipelagos are home to the majority of the population. The five main islands are: Sumatra (473,606 sq. km); Java/Madura (132,187 sq. km); Kalimantan, which comprises two-thirds of the island of Borneo (539,460 sq. km); Sulawesi (189,216 sq. km); and Papua (421,981 sq. km) which is part of the world's second largest island, New Guinea (BPS, 2003; Doak, 2004).

Figure 1.1: Map of Indonesia

Nearly 60% of Indonesia's land is forested and a significant portion is mountainous and volcanic. There are 500 volcanoes, 129 of which are still active. It has many natural hazards: occasional floods, severe droughts, tsunamis, earthquakes, and volcanic eruptions. Indonesia, part of the “Ring of Fire” a zone of frequent earthquakes and volcanic eruptions that encircles the basin of the Pacific Ocean, has the largest number of active volcanoes in the world (BPS, 2003).

At 211.1 million (2002) Indonesia is the fourth most populous nation in the world after China, India and the United States. It has 336 ethnic groups speaking 583 languages and dialects (Drakeley, 2005). Over two thirds of the population reside in Java Island, the centre of the country's economic and political power. Population growth rate is 1.49%, with a birth rate of 21.11 births per 1,000 population (2004 estimate). A breakdown of the age of the populations is: 0-14 years - 29.4%, 15-64 years - 65.5%, 65 years and over - 5.1%. The literacy rate is: 87.9% (2002) and the poverty rate: 27% (BPS, 2003).

Population density is the most serious problem in the country. The combined populations of the "special districts" of Jakarta and Yogyakarta and the provinces of West, Central and East Java totaled 121.5 million people in 2000. In that year the population of the special city of Jakarta was 9.5 million. By contrast, West Papua (formerly Irian Jaya) represents 22% of the total land mass, yet has only 1% of the population. The total population of the island of Sulawesi was over 14.9 million in 2000 (BPS, 2003).

The religious orientation of the Indonesian population is 85 percent Moslem and the rest Catholic, Protestant, Buddhist and Hindu. Some particularly remote parts of the country are still animist (BPS, 2003).

1.2 History

Over the centuries, merchants from Arabian Sea and Indian Ocean ports along with mystics and literary figures have plied their trade. Because commerce was more prevalent along the coasts of Sumatra, Java, and the eastern archipelago than in inland areas of Java, Islamisation proceeded more rapidly in the former than the latter. The major impetus to Islamisation was provided by Melaka, a rich city port that dominated the Strait of Malacca and controlled much of the archipelago's trade during the fifteenth century. The island states of Ternate and Tidore, off the west coast of Halmahera in Maluku, had Moslem sultans and Moslem merchants settled in the Banda Islands (Ricklefs, 1981; Frederick and Worden, 1992).

In 1511 the first Europeans in Indonesia, the Portuguese, arrived and decided to seize Maluku, the chief source of spices. The first Dutch fleet sailed from Holland in 1595 under Cornelis de Houtman. In 1602 the Dutch East India Company was formed to control trade with Indonesia. In 1605 they took Tidore and Ambon from the Portuguese. In 1619 the company captured Batavia (now Jakarta). During the 17th century the Dutch gradually extended their power over Java and Maluku (Lambert, 2003). Although the Portuguese broke the Islamic hold on Indonesia, they were eventually displaced in turn by the Dutch, who named the area the Dutch East Indies. The Portuguese had little influence in the rest of Indonesia (Frederick and Worden, 1992, Asian Info, 2005).

In 1806 the British and Dutch went to war. In 1811 the British under Lord Minto sailed to Batavia. The British soon captured all the Dutch possessions in Indonesia. The British abolished slavery and divided the country into areas called residencies for administration. However, in 1816, the British handed Indonesia back to the Dutch. Dutch rule continued until World War II and invasion by the Japanese. The Japanese occupation in the early 1940s shattered the Dutch colonial regime and opened up new opportunities for Indonesians to participate in politics, administration, and the military. Although Tokyo's primary goal was exploitation of natural resources especially oil, vitally necessary for the war effort in other parts of Asia, the Japanese tolerated political movements by Sukarno, Mohammad Hatta (1902-80) and others, especially on Java. With the co-operation of some Japanese military officers, Sukarno and Hatta declared Indonesia's independence on 17 August 1945, two days after Japan's surrender to the Allies (Frederick and Worden, 1992; Brown, 2003).

Indonesia was territorially a creation of Dutch imperialism, encompassing all the territories of the Old Dutch East Indies. Politically, Indonesia was created by early twentieth century nationalists who sought cultural, linguistic and social bases for national unity. Javanese culture was a strong influence (Frederick and Worden, 1992).

Throughout the archipelago the new state faced ethnic, religious, and social divisions. Early 1950s' practices of parliamentary democracy ended with Sukarno's adoption of “Guided Democracy” in the period 1959-65. Sukarno had a vast mass following, but his power base rested on the support of two antagonistic groups: the Armed Forces of the Republic of Indonesia (ABRI) and the Indonesian Communist Party (PKI). What has been officially described as a PKI attempted *coup d'état* on 30 September 1965 resulted in Sukarno's displacement from power, a massacre of PKI supporters on Java and other islands, and the rise of General Suharto to supreme power. Suharto's “New Order” regime placed ABRI firmly in control of Indonesia's political system and, to an extent, its economy as well. Friendly ties with Western countries and Japan were restored and Indonesia accepted large amounts of Western and Japanese aid and private investment. Under rational economic planning policies, the country experienced orderly

development and increases in the standard of living for most of the population. However, Suharto's strong anti-communism and insistence on using the *Pancasila*•, the ideological foundation of all ethnic groups and religions in society, contributed to a tightly controlled, centralised system (Frederick and Worden, 1992: Brown, 2003).

The Suharto regime's occupations of West New Guinea (which became Indonesia's West Papua Province) and East Timor (which became Timor Timur Province) were a focus of international criticism, stemming from charges of human rights violations. Re-elected repeatedly to the presidency, Suharto was regarded by many observers as indispensable to the system's stability and continuity (Frederick and Worden, 1992; Ananta *et al.*, 2005). Despite regular electoral process, there was no democracy during the Suharto era.

During the 1997 – 1998 economic crisis (further detail below), political turmoil became a material force in the form of the largest protest movement in Indonesian history. The movement in Jakarta, however, was hijacked by criminal elements, looters and other sinister gangs who burned Chinese, Christian and Muslim communities' shops, houses and buildings (Fic, 2003). Tense ethno-political religious conflicts in East Timor, Aceh, West Kalimantan, Central Kalimantan, North Maluku, Central Sulawesi became cumulative and provocative, and became intolerable in early 1998 forcing the resignation of President Suharto.

1.3 Socio-economic Situation

In the 30 years under the New Order government, Indonesia made substantial progress, particularly in stabilising political and economic conditions. A period of great economic growth was experienced from 1968 to 1986, although the inflation of the US Dollar which was used as a parameter during the time span period of those years must be taken into account. The Gross National Product (GNP) per capita increased from about US$50

• *Pancasila* is the philosophical basis of the Indonesian state. *Pancasila* consists of two Sanskrit words, "*panca*" meaning five, and "*sila*" meaning principle. The five principles are 1). Belief in the one and only God. 2). Just and civilized humanity. 3). The unity of Indonesia 4). Democracy guided by the inner wisdom in the unanimity arising out of deliberations amongst representatives. 5). Social justice for the whole of the people of Indonesia.

in 1968 to US$385 in 1986. This increase was primarily the result of the international oil boom in the early 1980s, from which more than 60% of the country's foreign exchange came. The drop in the price of crude oil and natural gas in 1985 forced the government to look at alternative sources of income, such as manufacturing, international trade, and service industries. This effort was considered successful. GNP per capita increased to approximately US$1,124 in 1996 while the economic growth was nearly five percent (van der Eng, 2002: BPS, 2003). All of these successes ended in mid-1997 when the Asian economy collapsed[•]. The value of the Indonesian currency in relation to foreign currency plunged and unemployment rose dramatically.

Indonesia experienced vast changes in both the economic and the political environment during 1998. Output was 15% below its 1997 level and inflation was at 75-80% for the year (BPS, 2003). Riots and demonstrations took place in a number of Indonesian cities, leading to but not ending after the resignation of President Suharto in May 1998 (Schwarz, 1999). The drought of 1997, the price rises associated with the collapse of the Indonesian currency *rupiah* and removal of subsidies and the income shocks arising from changes in demand combined to produce substantial change throughout the society. The effects of the crisis on the welfare of the population were varied. They differed by region, socio-economic group and demographic group. A study by Frankenberg and colleagues revealed that "…the impact of the economic crisis was great but varied in terms of who was affected, the changes in the dimensions of well-being and in the ways that people have responded" (Frankenberg *et al.*, 1999: 20). The populations of the major cities in Indonesia were heavily affected by the crisis.

[•] The Asian economic collapse was a period of economic unrest that started in July 1997 in Thailand and South Korea, and affected currencies, stock markets, and other asset prices in Asian countries. The Asian financial crisis was initiated by two rounds of currency depreciation that began in the early summer of 1997. The first round was a precipitous drop in the value of the Thai baht, Malaysian ringgit, Philippine peso, and Indonesian rupiah. Governments countered the weakness in their currencies by selling foreign exchange reserves and raising interest rates, which, in turn, slowed economic growth and made interest-bearing securities more attractive than equities. The currency crises also revealed severe problems in the banking and financial sectors of the troubled Asian economies (Nanto D.K., 1998).

The economic crisis of 1997 is typified by the reported drop in economic growth rate to a negative 13%. There was uncertainty about when the crisis would end (Tjiptoherijanto, 1997; BPS, 2003). In the succeeding period, the political situation became unstable and continued so in recent years when ethno-religious crises have led to complex emergency situations in several provinces included Maluku, North Maluku, Central Sulawesi, Papua and West and Central Kalimantan as well as Aceh where a group is fighting for independence**.**

1.4 Government, Politics and Administrative Divisions

Nowadays, Indonesia is a multiparty republic in which the president has the primary executive power and serves as leader of the two-house legislature. Since 2004 the president and vice president have been popularly elected to five-year terms. The 550 members of the House of Representatives also are elected to five-year terms. The Regional Representatives Council, which was created in the early 21st century, reviews laws that affect the provinces. It consists of four members from each province. The members of the House and the Council together form the People's Consultative Assembly, which meets at least once every five years to help outline national policy.

Indonesia is divided into 33 provinces, including two special regions, Jakarta the special capital city and Yogyakarta the special region of Sultanate. The provinces are further sub-divided into smaller entities of municipalities and districts that altogether total 91 municipalities and 349 districts. The lowest administrative units are sub-districts and villages. In 2004, there were 5,263 sub-districts and 69,929 villages (Depdagri, 2004).

1.5 Trends in Health Status of the Indonesian Population

A comprehensive approach to the promotion of health status and the improvement of life expectancy has been initiated from MoH Republic of Indonesia using the family as the focal point. In general the problems faced by the Indonesian people in health development are:

- rapid population growth
- need for quality of life improvement
- the poor level of education, comprehension, behaviour and habits of the community pertaining to health
- the low socio-economic level of the community
- variations in development and the potential to develop
- the physical and biological environments, which are not yet properly controlled
- the geographical constitution of the country; widespread communities with inadequate means of communication
- decrease in the quality of the environment (MoH, 2005a).

A further major challenge is that health problems are becoming more and more complex in Indonesia, exacerbated in recent years by the impact of complex emergencies.

1.5.1 Life Expectancy

In line with national health development, life expectancy at birth has increased from an average of 45.7 years in 1967 to 66.18 years in 2003. The highest life expectancy rate is in the Special Region of Yogyakarta (72.17 years), followed by the Special Region of the Capital City of Jakarta (72.12 years). The lowest is in West Nusa Tenggara province (63.51 years) (MoH, 2005a).

1.5.2 Morbidity

Several communicable diseases such as malaria, Dengue Hemorrhagic Fever (DHF) and Human Immunodeficiency/Acquired Immune Deficiency Syndromes (HIV/AIDS) have been observed to show increasing trends of morbidity in the Indonesian population. The incidence rate of DHF which was noted as 23.22 per 100,000 residents in 1996 increased to 35.19 per 100,000 residents in 1998. Pulmonary TB is still an illness requiring attention, though its prevalence has decreased from 2.9 per 1,000 residents in the period 1979-82 to become 2.4 per 1,000 residents at the end of 1996. This incidence is not evenly distributed among all the provinces. The national prevalence of AIDS in Indonesia is 0.11 per 100,000 residents with prominent disparities between provinces. In

Jakarta the prevalence of AIDS is 10 times higher than the national average, i.e. as high as 1.0 per 100,000 people. In Irian Jaya the prevalence of AIDS is 40 times higher than the national figure, i.e. 4.4 per 100,000 people (MoH, 1999b).

Degenerative diseases and non-communicable diseases also show rising trends. The results from the Household Health Survey of 1995 show 83 per 1,000 people suffering from hypertension, and ischaemic heart disease and stroke are suffered by 3 and 2 per 1,000 people respectively. Emotional and mental disturbances among people aged 5-14 years and above 15 years old are respectively 104 and 140 per 1,000 people. Traffic accidents in Indonesia in 1994 accounted for 0.19 victims per 1,000 people, rising to 0.27 victims per 1,000 people by 1997 (MoH, 1999b).

1.5.3 Mortality

Mortality rates have shown a gradual decline. The persistence of many of the communicable diseases, which are still of public health significance and the re-emergence of others, are of concern. The increase observed in non-communicable diseases, particularly CVD (Cerebral Vascular Disease) and the degenerative diseases, is another important issue that needs to be addressed. Nutritional concerns of importance are PEM (Protein Energy Malnutrition) and micronutrient deficiencies, particularly iron deficiency anaemia, iodine deficiency and vitamin A deficiency (WHO SEARO, 2003a). The maternal mortality rate has shown an encouraging decline over a sixteen year period, although it is still unacceptably high. Table 1.1 below shows the IMR (Infant Mortality Rate, UFDR (Under Five Death Rate) and MMR (Maternal Mortality Rate) between 1967 – 2002.

Table 1.1: Infant Mortality Rate, Under Five Death Rate and Maternal Mortality Rate for the period 1967 to 2002 (MoH, 2005a)

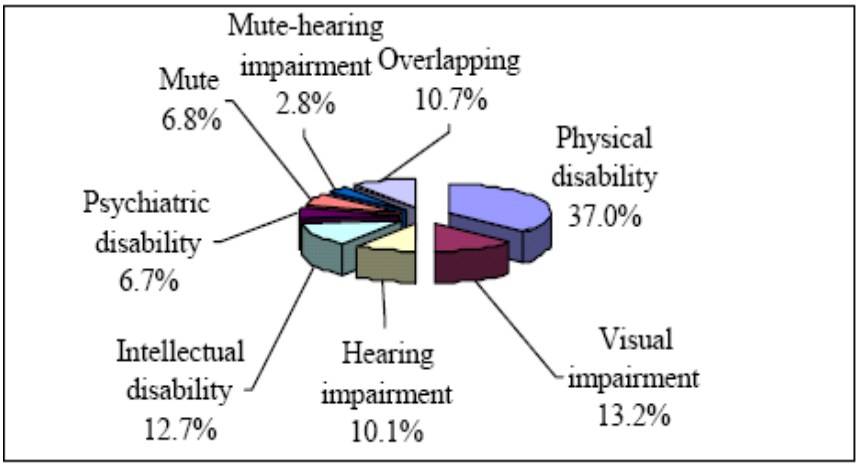
	1967	1986	2000	2002
IMR (Infant Mortality Rate) per 1,000 live births	145	N/A	N/A	33
UFDR (Under five death rate) per 1,000 live births	N/A	111	N/A	45
MMR (Maternal Mortality Rate) per 100,000 live births	N/A	540	230	N/A

1.5.4 Disability

An individual legally defined as having a disability is any person who has a physical or intellectual disability that can disrupt their livelihoods and/or constraint him/her from performing normal activities. It includes: a) the physically disabled b) the intellectually disabled c) the physically and intellectually disabled. The physically disabled are those who are impaired in terms of body movement, visual ability, hearing, or speaking (JICA, 2002). Reported medical data estimates an overall population figure of 0.31 people per 1,000 with a disability (ibid).

The figure below shows the range of disabilities in Indonesia.

Figure 1.2: Percentage distribution of disabilities in the Indonesian population in 2000 (BPS, 2001 in JICA 2002)



It is estimated 6 million people with disability (JICA, 2002). According to a recently commissioned disability report for the East Asia and Pacific Region (EAP), poverty is the underlying cause of disability, whether through malnutrition, lack of health services, unsafe living and working conditions or other reasons. Furthermore, in a vicious circle, people with disabilities face barriers in attitudes, education, employment, and public services that prevent their escape from poverty (SINTEF, 2005). Percentage of disability in urban and rural areas in Indonesia is 34.29% in urban area and 67.71% in rural area (BPS, 2001 in JICA, 2002).

The Government of Indonesia and non-governmental organizations (NGOs) provide health, education and other social services for persons with disabilities. However, many projects and facilities are concentrated in the larger cities. The public sectors have to cover this health problem. Early detection of disability, parental or community education and raising awareness of disabilities remains an issue and, if action is taken, could perhaps lower the scale of disabilities caused by disease (JICA, 2002).

1.6 Health Development Efforts in Indonesia

Health developments implemented during the last 30 years have succeeded in providing health service facilities and infrastructures evenly throughout Indonesia. In 1999 the main approach to health development was based on the design and strategy of the health development set out in “Healthy Indonesia 2010” (MoH, 1999a). The new mission of the National Health Development Programme is to lead and initiate health-oriented national development; maintain and enhance the health of individuals, families and communities along with their environments; maintain and enhance good quality, equitable and affordable health services; and promote public self-reliance in achieving good health. The main focus of the new approach is:

- decentralisation as the key to health sector reform, in the context of broader political decentralisation
- an emphasis on health prevention and health promotion, "The Healthy Paradigm", rather than on curative services

- an effective human resources development programme, to support decentralisation
- improving access to quality basic health services through a community managed care approach (WHO CSS, 2002).

According to the World Bank, Indonesia has made significant progress in health outcomes over the last decades. For instance, infant mortality dropped from 118 deaths per thousand births in 1970 to 35 in 2003 and life expectancy increased from 48 years to 66 years over the same period. This progress owed much to the expansion of public health provision in the 1970s and 1980s as well as programmes in family planning. However, new challenges have emerged as a result of social and economic changes (World Bank, 2005a):

1. Disease patterns have become more complex. For example, non-communicable diseases have increased and communicable diseases remain high.
2. There are important regional and socioeconomic inequities in the health system, e.g. much of the population has limited access to health services.
3. Performance and utilisation of public health services is declining and the private sector is now the major source of health care
4. Health financing is low and inequitable
5. Decentralisation poses new challenges and presents new opportunities
6. HIV/AIDS transmission rates are increasing but the epidemic remains largely localized to several provinces.

Efforts have been made to reallocate some of the subsidies to public hospitals to support primary health care services, particularly for the underserved, by means of converting public hospitals into self-supporting service units. The “Health Card” programme was also introduced to improve access by the poor to health care services. The public has been encouraged to join the "Voluntary Managed Care Plan" (JPKM) for better health protection and access to services through small-scale voluntary insurance schemes

(WHO SEARO, 2003a; Wheller, 2004). The JPKM is a compulsory management method for the provision of pre-paid comprehensive and continuous quality health care. All pre-paid health care programmes run by the government as well as private sectors have to abide by these principles of management.

At present Indonesia is starting to free itself from the grip of poverty, low understanding of a healthy life, nutritional deficiency and diseases that erode work productivity. Nevertheless, social indicators, including health indicators, still reflect the characteristics of a developing country. Difficult challenges are still to be faced by Indonesia in the implementation of developments in health care arising from the impact of ethno-political conflict and disaster. The people who were victims of the conflicts and recent natural disasters, by virtue of their numbers, have contributed to a continuing low level of current health status of the country.

1.7 History of Complex Emergencies in Indonesia

Indonesia has changed from being a stable country to one that is vulnerable and prone to man-made disasters such as civil unrest, terrorism and social/ethnic conflict as well as other conditions that tend to create a high tension environment. Underlying causes include the transmigration policy, sectarian disputes, the Asian economic crisis, the fall of authoritarian rule, and a backlash against civil and military abuses.

Conflict in Indonesia has a complex mix of historical, ideological, political, social, economic and structural causes. The newly independent Indonesia in the 1940s experienced regional rebellions in Aceh, Sumatra, West Java, Sulawesi and Maluku against central control from Jakarta, as well as political disagreement at the national level between non-Muslim, modernist and traditionalist Muslim groups over the nature of the constitution regarding Islamic law and its obligations. In the mid-1960s, the killing of an estimated half a million people in an anti-Communist purge resulted in the rise of General Suharto to the Presidency and the beginning of the New Order. Although aspects of Indonesia’s regional conflicts can be traced to events and issues that occured in the 1950s and 1960s, the New Order period has had a profound influence on the

current situation (Pudjiastuti, 2002; Mawdsley *et al.*, 2002: Bourchier and Hadiz, 2003). The New Order government had implemented repressive and coercive approaches to contain any potentially serious conflict. These approaches resulted in temporary settlements and only short-term resolutions.

Democratisation, economic reform, and the lifting of the social and political order associated with the Suharto era since May 1998 seem to have coincided with an exacerbation of divisions within Indonesian society on ethnic, religious, political and social grounds. To a large extent these tensions can be explained by the policies of the Suharto era, by policies of centralisation, exploitation of the periphery, environmental degradation, human rights abuses, and a preclusion of civil society (Wilson, 2001).

Indonesia is one of many countries feeling the burden of a large population crowded into a relatively small area. The Indonesian government's solution was to move landless peasants and other peoples from the crowded central islands of Java and Bali to the outer islands of Irian Jaya, Kalimantan, Sumatra, and Sulawesi. The idea was to use the migrants to develop public infrastructures such as roads, schools and hospitals to put these otherwise “useless” lands to use. In the past two decades the government moved more than six million people from the crowded central islands. This “transmigration policy” was the Indonesian government’s solution to over-population.

However, Indonesia's transmigration programme, one of the largest resettlement programmes in the world, has been much criticized. Supporters point to the safe and orderly resettlement of millions of people, alleviating pressure on land in inner islands and contributing significantly to the development of the outer islands. But detractors argue that considerable resources have been wasted in settling people who have not been able to move beyond subsistence level, with extensive damage to the environment and deracination of tribal people (World Bank, 1994). In particular, the government policy of transmigration, initiated under the New Order period, stoked up considerable regional resentment, largely contained throughout the years of the Suharto regime by firm governmental control.

Violent confrontations have occurred in Kalimantan, Aceh, Sulawesi, and Papua in recent years. Among indigenous people, the transmigration policy is considered a new type of invasion by the Javanese and Madurese, who also brought Islam to traditionally Christian or non-Muslim areas (HPCR, 2001).

Beginning in late 1996, a series of anti-Chinese riots swept through many small towns in Java. Following Indonesia's economic collapse in late 1997, small-scale anti-Christian and anti-Chinese rioting engulfed the country, fanned by the rhetoric of hard-line military officers but also driven by the participation of radical Muslim militias (Morris 2002). High profile conflict in East Timor, Central and West Kalimantan, Central Sulawesi, West Papua, Maluku, North Maluku and Aceh have attracted international attention (Wilson, 2001). Further, there has been an increasing realization that most regions of Indonesia are prone to destructive conflict (Smith, 2000; Welsh, 2003).

In the same period, Indonesia has experienced an increasing number of terrorist attacks. While not all of these have been linked to radical Muslims, attacks against churches certainly point in this direction. Most occurred on Christmas Eve 2000, when bombs exploded in or near Catholic and Protestant churches in the cities of six different provinces (Morris, 2002; Smith, 2005). Moreover, the Bali bombing in 2002 and the Jakarta bombing of the Marriot hotel in 2003 and outside the Australian embassy in 2004 increased the number of terrorist attacks in Indonesia.

Ethno-nationalism has been a significant manifestation of ethnic conflict in New Order Indonesia. In East Timor, Papua, and Aceh, conflicting groups identified as East Timorese, Papuan, and Acehnese conceived of themselves as distinct nations on the basis of ethnic differences. East Timor and Papua were integrated into Indonesia well after the revolution of 1945 when significant Indonesia nationalist sentiment developed. Several ethnic groups joined the Indonesian nationalist movement and fought against the Dutch. East Timor and Papuan groups however, resisted from the moment of their inclusion in the new state, resistance in Aceh emerged later. Consequently, for many East Timorese and Papuans, ethno-nationalism reflected a rejection of the fact and

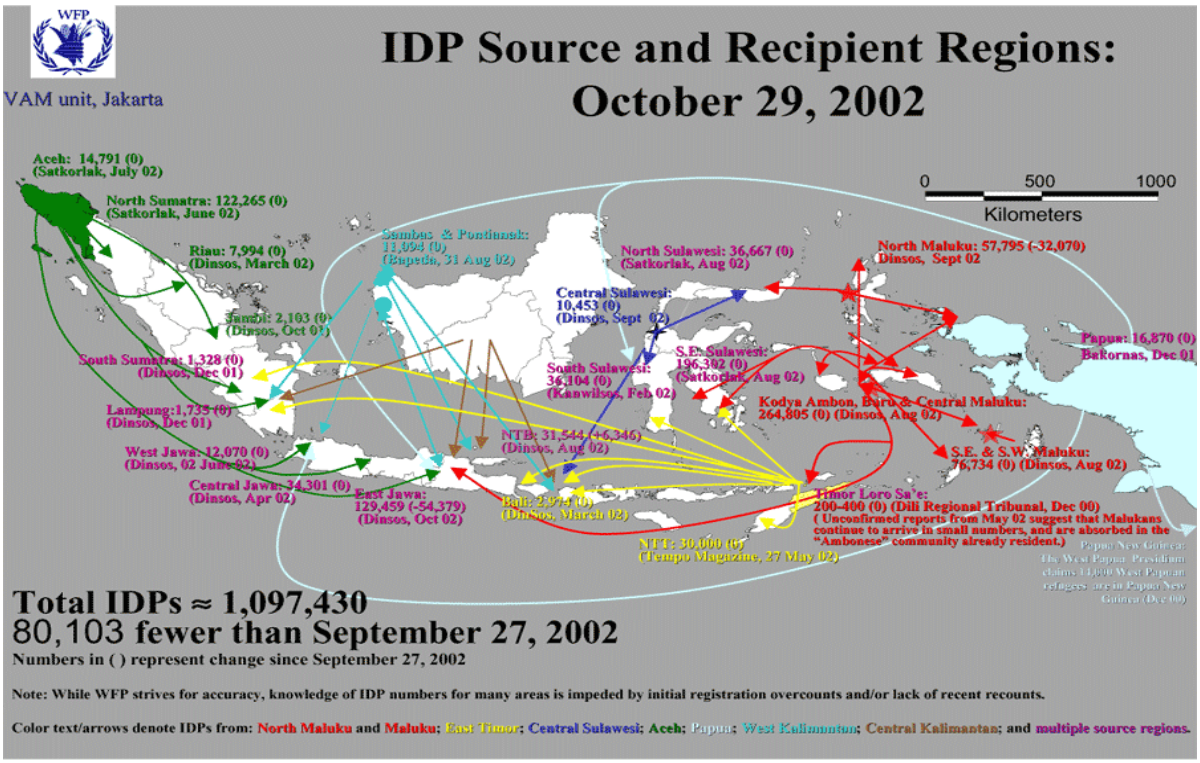
process of integration into the Republic of Indonesia. The ethno-nationalist struggle in Aceh represented a reaction to the treatment of Acehnese under the Indonesian state (Kingsbury and Aveling, 2003; Bertrand, 2004).

In other parts of Indonesia, violence erupted along ethno-religious lines in Kalimantan, Maluku, Central Sulawesi and several other regions. According to the report of the Department of Transmigration R.I. (2002), 1.4 million people became IDPs within the country due largely to internal conflict.

In mid 2003 535,000 still remained as IDPs who had lost their productive assets as a direct consequence of conflict or given them up in exchange for food (Global IDPs, 2004).

Indonesia remains highly volatile to reaction against perceived threats to matters of Islamic identity, and a sectarian conflict is a more effective recruitment vehicle. Up to the present there is still conflict in some parts of Central Sulawesi.

Figure 1.3: Map of Indonesia showing the IDPs' flight to safer places



The United Nations has, during 2004, used a working figure of 535,000 IDPs although the government, since January 2004, considered the IDPs as 'vulnerable people', rather than 'displaced'. The 535,000 figure is the result of UN-Government assessment missions conducted in all IDP-affected areas during 2003 (iDMC, 2007a). According to the Ministry of Social Affairs, some 155,000 IDPs were "handled" during 2004, bringing the total number of conflict-induced displaced down to 342,000 IDPs as of March 2005 (iDMC, 2007a). Between 200,000 and 350,000 people are still displaced by conflict in Indonesia in 2006 (ibid.)

There are currently no reliable estimates available on the number of people who are still displaced or living in situations akin to displacement. Officially, since January 2004, there are no conflict-IDPs left in the country and the government no longer issues comprehensive national IDP figures. The table below shows a breakdown by province using a variety of sources:

Table 1.2: Internal Displacement Profile in Indonesia.
iDMC (2007a).

Province	Number of IDPs	Year
Aceh (including North Sumatra)	140,000 – 150,000	2006
Papua	1,200	2006
West Timor	10,000 – 40,000	2006
Central Sulawesi	40,000	2005
North Maluku	15,000	2005
East Jawa	63,000	2004

The remainder of this chapter focuses on the religious conflict between Muslim and Christian in North Maluku province and ethnic conflict in Central Kalimantan province. Both conflicts created a huge number of IDPs, many of whom fled to Manado Municipality, North Sulawesi Province and Sampang District, East Java Province. These regions were selected for this research as the recipient IDP areas.

1.7.1 Complex Emergency in North Maluku Province

North Maluku (Indonesian: *Maluku Utara*) is one of the new provinces in Indonesia. It comprises the northern part of the Maluku Islands and was previously part of the province of Maluku. The current capital and largest population centre is the island of Ternate. The population of North Maluku is 785,059 (2000 census), making it the least populous province in Indonesia (Wikipedia, 2005a).

Figure 1.4: Map of North Maluku Province

In 1999 and 2000 a series of ethnic, political and religious riots broke out. In this province the conflict has been seen as typically religious in character and an extension of the conflict in Ambon and Maluku Province. However, although religion became an important factor in the later stages of the North Maluku conflict, the initial violence was not religious in character nor closely connected to the Ambon conflict, but was related to the government's transmigration policy.

In North Maluku it was estimated that the conflict led to the deaths of around 3,000 people, the displacement of 250,000, although around 40 percent of these would probably not be considered as "real" IDPs as they returned to their home area. Moreover, approximately 20,000 houses were destroyed (Tomagola, 2000; Rabasa and Chalk 2001; Mawdsley, 2002).

Lack of strong central government action during the riots in Maluku and North Maluku was cited by *Laskar Jihad*, a Muslim paramilitary extremist group renowned for its fanaticism and brutality (it aimed to eliminate Christians from the Moluccas and Sulawesi Island) in its defence of Muslims from Christian attacks. A coalition of Christian tribes in northern Halmahera, in turn, attacked Muslims living there, and Muslims (assisted by Islamic volunteers from Java) launched retaliatory attacks (Smith, 2000; Kingsbury and Aveling, 2003). The violence in this area has been seen as largely religious in character and has significantly changed the situation of the country particularly regarding security and freedom of worship.

Thousands of Makians fled to neighbouring Ternate Island, which set off a reaction with people sympathetic to the Kao people being attacked in Ternate and ending in outbreaks of violence between Christian and Muslim communities in many parts of Halmahera. Thousands died in the violence with more being displaced (Christians from Ternate to North Sulawesi and Halmahera; Muslims from Halmahera to Ternate).

1.7.2 Complex Emergency in Central Kalimantan Province

One of the two complex emergencies examined in this thesis took place in Kalimantan *Tengah* or Central Kalimantan, one of four Indonesian provinces in the Indonesian part of Kalimantan Island. The province has a population of 1,874,000 million (2002 census). This represented a 2.7% annual growth between 1990 and 2000, one of the highest provincial growth rates in Indonesia during that time (Government of Central Kalimantan, Indonesia, 2003; Wikipedia, 2005b).

Figure 1.5: Map of Central Kalimantan Province

A number of ethnic groups reside in this Province, including the indigenous Dayak, Madurese, Javanese, Bataknese, Chinese, Bugisnese, Makassarese and small numbers of ethnic groups from other parts of Indonesia. In 1996–1997 an outbreak of violence broke out between Dayaks and Madurese settlers and in 1999 violence erupted again in West Kalimantan, with the local ethnic Malay community, supported by the Dayaks, against the Madurese (Global IDP, 2004). On 20 February 2001 violence erupted again when the Dayak warriors attacked Madurese settlers living in the Central Kalimantan port of Sampit. The province had been "ethnically cleansed" of Madurese, 6-7 percent of the population (ICG, 2001).

The violence in Sampit started on the night of February 17-18th 2001 when a Dayak house was burned down. Rumours spread that an ethnic Madurese was responsible and immediately a band of Dayaks went into a Madurese neighbourhood and began burning houses. In the ensuing violence, a Dayak and a Madurese were killed (ICG, 2001; Global IDPs, 2004). In the following weeks the killings spread to other areas in the province.

The impact following this conflict was greatest in Sampit town in Central Kalimantan where over 40% of the population had been evacuated or killed, but it was felt also

across the rural areas. The provincial government officially estimated that 500 people died in Sampit town and its surroundings, but unofficially civil servants reported much higher fatality rates of around 3,000 dead (ICG, 2001; Global IDP, 2004).

Demographically, the province was radically changed after the conflict. Around 200,000 Madurese from Central Kalimantan were evacuated, some to temporary camps in South Kalimantan and the remainder left in the jungle. The state shipping line, *Pelni*, mobilised six ships for this task, while other IDPs were evacuated by naval vessels. However, the majority were shipped to the island of Madura, off the coast of East Java (ICG, 2001; Global IDP, 2004).

Among the causes of this IDP problem were government policies and competition among various indigenous groups for limited resources. The previous government policy of transmigration—giving people economic incentives to repopulate different areas of the country—altered the population balance in West Kalimantan and Central Kalimantan, especially in cities such as Sambas, Pontianak and Sampit. This led to conflicts among the various ethnic groups, including Chinese, Malay, Madurese, and Dayak (Achwan e*t al.*, 2005). Further, the non-Madurese migrants such as Malay, Chinese, Sumatranese and Javanese did not dominate the informal sector of the economy (Smith, 2005). The causes of the conflict are further discussed in Chapter Two.

1.8 The Areas Receiving IDPs

The result of the conflict in North Maluku province was the IDPs flight to safe areas. Most of the IDPs from North Maluku arrived in North Sulawesi province in December 1999 – February 2001. At that time the number of IDPs who arrived in that province numbered 35.000 (Dinkesos Manado, 2003). The displaced population came from several islands in North Maluku province.

Conflict between Dayak and Madurese ethnic groups in Central Kalimantan had occurred several times over the previous decade. As a result of the conflict in Sampit Central Kalimantan, the Madurese who took flight to Madura Island were placed in IDPs barracks and relatives' houses. By early April 2001 almost the entire Madurese

population, numbering 180,000 persons, had fled from the conflict areas and an influx of 86,261 IDPs was experienced in Sampang District in Madura Island, East Java province (Refugee International, 2001; UNOCHA Indonesia, 2003; Global IDPs, 2004). The district, with limited resources for education, employment, and farming for its own population, then faced the added difficulties caused by the influx of IDPs.

Inevitably, the health profile of the two recipient areas, Manado Municipality, North Sulawesi Province and Sampang District, East Java Province was affected. This is further examined in Chapter Six. Prior to this, some details about the recipient areas are provided in terms of their socio-demographic profile and health system.

1.8.1 Manado Municipality, North Sulawesi Province

i. Geography, Population and Religion

Manado is the capital of North Sulawesi Province on the northeast coast of Sulawesi Island. The area of the land is 15,726 Ha. Manado Municipality is a waterfront city with 187 kilometres of coast line. It is surrounded by hills. The climate is tropical with the temperature averaging around 24° - 27° C. There are seven wet months and five dry ones (Dinkes Manado, 2003).

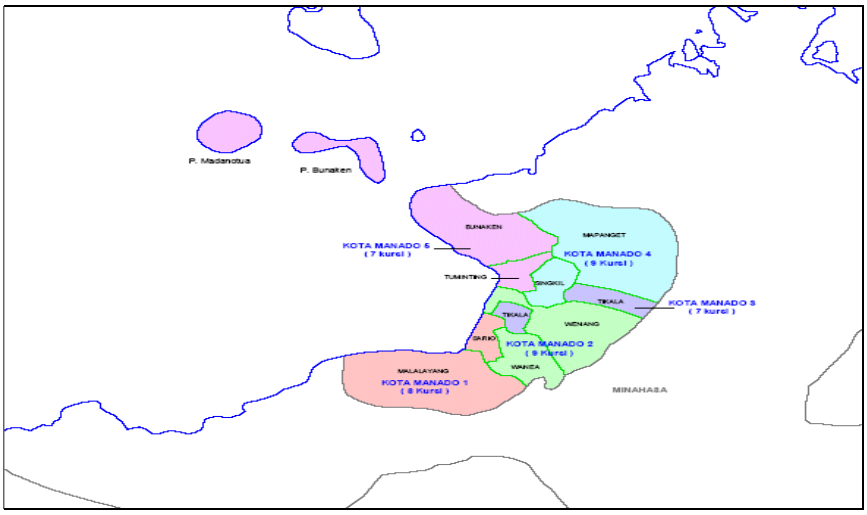
Figure 1.6: Map of North Sulawesi Province

Manado Municipality is divided into nine sub-districts: Bunaken, Tuminting, Singkil, Wenang, Tikala, Wanea, Sario, Malalayang and Mapanget. These sub-districts are further sub-divided into smaller entities of *Kelurahan* or villages. Altogether there are 87 villages (Dinkes Manado, 2003).

The population of Manado Municipality, based on the 2004 census, is 417.787 with 209.443 males and 208.344 females. In 2004 the number of poor people with an absence of means for the satisfaction of basic human needs was 4.14%. Life expectancy in Manado was 70 years for males and 72 for females (BPS Sulut, 2007).

In 2002 the adult literacy rate was 99.8% of total population. Adjusted real per capita expenditure in *rupiah* was Rp. 587,300 per year (BPS, BAPPENAS and UNDP, 2004). The Human Development Index (HDI) for Indonesia, which combines measures of life expectancy, educational attainment and income into a single figure indicated that Manado was the 8th highest of the 440 total municipalities and districts in Indonesia (ibid). The population was 57% Christian Protestant, 8% Catholic, 31% Moslem, 2% Hindi and 2% Buddhist (MoH, 2006; Government of Sulawesi Utara, 2006).

Figure 1.7: Map of Manado Municipality



ii. Epidemiological Profile

Infant mortality was 3.54 per 1,000 live births/year in 2000 and decreased to 2.16 per 1,000 live births/year in 2002. The under-5 mortality rate was 0.48 per 1,000 live births/year in 2000 and decreased to 0.19 per 1,000 live births/year in 2001, but increased again to 0.37 per 1,000 live births/year in 2002. The maternal mortality rate which was 42 per 100,000 live births/year in 2000 increased to 66 per 100,000 live births/year in 2002 but was still below the national average (Dinkes Manado, 2003).

In 2002, immunisation of infants based on Measles vaccination was 97.2% coverage and in the same year, it is estimated that 81% have access to clean water and sanitation coverage is estimated at 61% (Dinkes Manado, 2003). According to the survey conducted, there was no formal report of the change of health profile in this recipient area.

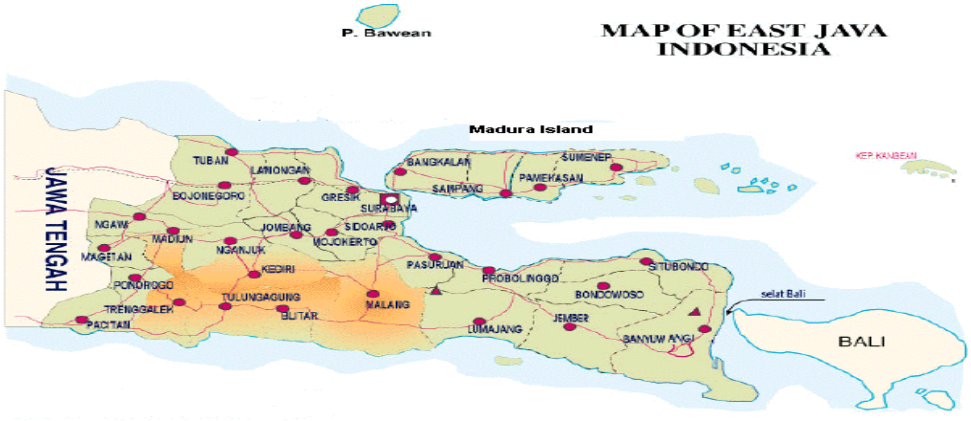
Common diseases of the local community in *puskesmas* based on the Manado health profile revealed that respiratory tract infection, malaria, dermatitis, hypertension, muscle diseases, nervous diseases and oral diseases were common. People attending hospital outpatient departments suffered from fever, diabetes mellitus, respiratory infections, heart disease, hypertension, tuberculosis, skin diseases, stroke, and dyspepsia. Inpatients suffered from diarrhoea, malaria, typhoid, dengue hemorrhagic fever, hepatitis, stroke, kidney failure, pneumonia, gastritis and pulmonary tuberculosis (Dinkes Manado, 2003).

1.8.2 Sampang District, East Java Province

i. Geography, Population and Religion

The position of Sampang District is on Madura Island in East Java Province. There are twelve sub-districts in this district namely Sreseh, Torjun, Sampang, Camplong, Omben, Jrengik, Tambengan, Kedundung, Banyuates, Sokabanah, Robatal and Ketapang. These sub-districts are further sub-divided into smaller entities, villages of which there are 186 (Dinkes Sampang, 2003). Adult literacy rate is 56.2% from total population (UNDP, 2004)

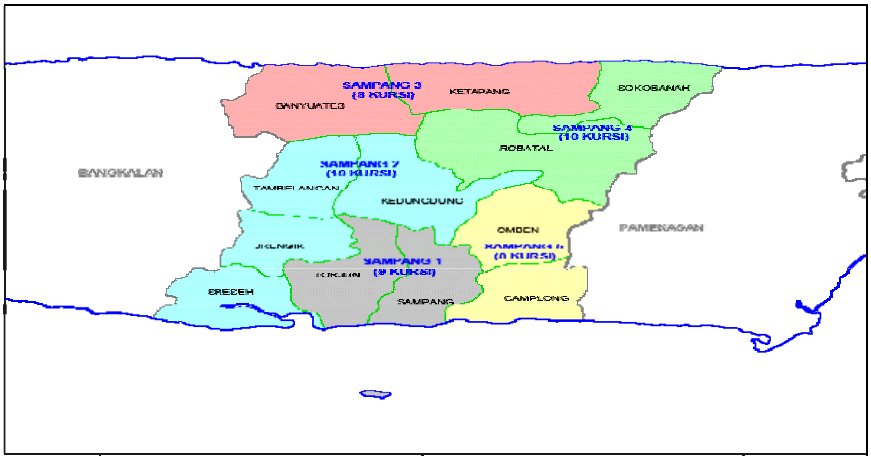
Figure 1.8: Map of East Java Province



The population of Sampang District (including the IDPs), based on the 2004 census, was 847,361. The number of poor people with an absence of means for the satisfaction of basic human needs was 56.96% of the total population (BPS Jatim, 2005). In 2002 the adult literacy rate was 56.2% of the total population. Adjusted real per capita expenditure in *rupiah* was Rp. 588,300 per year (BPS, BAPPENAS and UNDP, 2004). Indonesia's Human Development Index (HDI) indicates that Sampang was the second from the bottom of the total 440 municipalities and districts in Indonesia (450) (ibid). Religious affiliation was 99% Moslem (BPS Jatim, 2005).

Figure 1.9: Map of Madura Island

Figure 1.10: Map of Sampang District



ii. Epidemiological profile

In 2002, life expectancy in Sampang was 59 years for males and 61 years for females. Infant mortality was 70.26 deaths per 1,000 live births/year. The under-5 mortality rate was 80 deaths per 1,000 live births/year. Life expectancy, infant mortality rate and under 5 mortality rate in Sampang were above the national average. Maternal mortality of 300 deaths per 100,000 live births/year was one of the highest in Indonesia (Dinkes Sampang, 2003, MoH, 2005a). Common diseases of the local community presenting in *puskesmas* in this district were dengue hemorrhagic fever, pulmonary tuberculosis, diarrhoea, cholera, dysentery, typhoid, pneumonia, leprosy, measles, hepatitis and tetanus neonatorum (ibid).

In the same year the infant immunisation programme based on measles vaccination covered 95.7% of the population. It was estimated that 12.24% had access to clean water. Sanitation coverage was estimated at 10% (Dinkes Sampang, 2003). These figures indicate a much worse situation than that in Manado.

This chapter has set out the geography of Indonesia, the political structure of its government, its health systems and their development; also the history and causes of the complex emergencies which affected the country, especially in the conflict zones and recipient IDP areas.

The next chapter will review the causes and consequences of complex emergencies, focusing in particular on the experience of Indonesia.

Chapter Two

Complex Emergencies:
Causation and Consequences to Health

Introduction

For more than two decades there has been a significant and highly visible increase in complex emergencies worldwide. According to the Organisation for Economic Cooperation and Development (OECD), the term "complex emergencies" was coined in Mozambique in the latter half of the 1980s (OECD, 1999). An important factor influencing its coinage and usage was the need for international aid agencies to acknowledge that the 'emergency aid' or humanitarian assistance needs were being generated by armed conflict as well as by periodic 'natural disaster' events, such as cyclones and droughts, whilst avoiding use of terms such as 'war', 'civil war' and 'conflict' which were sensitive terms in the Mozambican context at the time (OECD, 1999: 5-6). Since then, the international community has been more directly involved in efforts to provide humanitarian assistance in areas of ongoing armed conflict. As a consequence the term 'complex emergency' has entered widespread usage as a way of differentiating between those situations where armed conflict and political instability are the principal causes of humanitarian needs from those where natural hazards are the principal cause of such needs (ibid). This term describes a broad range of phenomena, ranging from civil to ethnic-religious conflicts.

Many of these complex emergencies have resulted in extended conflict situations and long-term instability. Their impact is felt in all aspects of a community: the economy, livelihoods, human rights, social cohesion, civil order, education and health. Complex emergencies directly and indirectly affect public health, the health system of the country and the health status of the population, either in the zone areas of conflict or in the safe areas that received the IDPs. There may be an increase in the health needs of individuals

resulting from population displacement, deterioration in service delivery and living environments caused by complex emergencies. Under these complex circumstances, health issues require particular consideration, principally the capacity of health systems to respond to the short and longer-term health needs of the populations that have been displaced.

This chapter presents an overview of complex emergencies; their causes and consequences. The views of various scholars are considered in order to discuss the nature of complex emergencies. The purpose is to identify and gauge the impact of the various factors that constitute complex emergencies on the population and health systems in relation to this research. The particular focus is on the effect on the health systems of the country, especially at municipal and district levels in the areas which received the displaced populations.

Two major issues emphasised in the thesis are the health impacts of forced displacement, notably that experienced by IDPs in two recipient safe regions in Indonesia, and the effectiveness of the public health sector response to IDPs health needs in those areas.

2.1 Complex Emergencies

Building on the definition at the beginning of this chapter, the common understanding of complex emergencies is derived from United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA), which uses the term to define "a humanitarian crisis in a country, region or society where there is total or considerable breakdown of authority resulting from internal or external conflict and which requires an international response that goes beyond the mandate or capacity of any single agency and/ or the ongoing United Nations country programme" (UNOCHA, 1999). Such "complex emergencies" are typically characterized by extensive violence and loss of life, massive displacements of people and widespread damage to societies and economies (ibid).

Complex emergencies are human-made, with multiple contributing factors (Abdallah and Burnham, 2000). The characteristics of complex emergencies commonly include:

administrative, economic, and social decay and collapse; high levels of violence; cultures, ethnic groups and religious groups at risk of destruction; and catastrophic public health emergencies in which vulnerable populations are at greatest risk of exposure to diseases (Stewart, 2002; Burkle, 1999; Natsios, 1996). They also include disruption and deterioration of publicly provided infrastructure and services; all these reflect another key element of contemporary conflict, the targeting of civilians and their livelihoods, often spilling over into neighbouring areas.

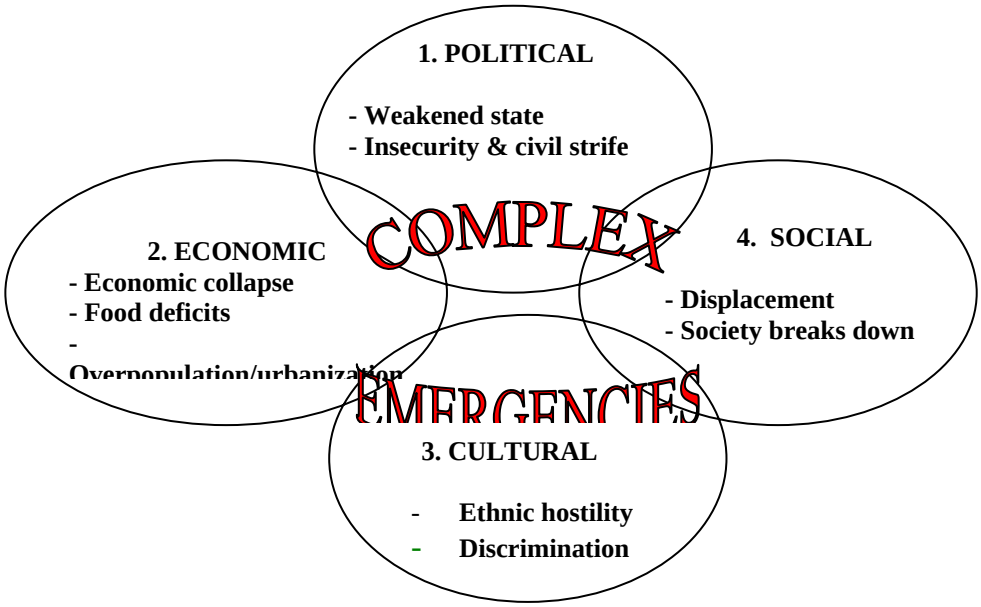
The effects of complex emergencies can spill over into safe areas of a country or over national borders. The arrival of displaced persons can threaten internal stability due to the additional burden they place on the recipient area.

2.2 Causes and Types of Complex Emergencies

It is clear that complex emergencies are caused by extensive conflict among the people. Conflict occurs when two or more parties perceive that their interests are incompatible, express hostile attitudes or pursue their interests through actions that damage the other parties (CAI, 2004). These parties may be individuals, small or large groups or countries. Interests can diverge in many ways: over resources, territory, money, energy sources, food - and how it should be distributed; over power, how control and participation in political decision-making are allocated; over identity, concerning the cultural, social and political communities to which people feel tied; over status, whether people believe they are treated with respect and dignity and whether their traditions and social position are valued; over values, particularly those embodied in systems of government, religion, or ideology (CAI, 2004; Stewart, 2002). Poverty can exacerbate the onset of conflict, frustration and aggression causes some people to become radical and create violence.

In understanding these different dimensions underlying the causes of conflicts Abdallah and Burnham (2000) usefully draw attention to four factors; political, economic, social and cultural that they believe usually surround complex emergencies (Figure 2.1).

Figure 2.1: Key Factors Surrounding Complex Emergencies
Adapted from Abdallah and Burnham (2000)



From this figure it is clear that violent conflict has various roots. It may arise out of a dispute over territory, over the control of land, or over the exercise of power in a piece of territory. It may be essentially political, aimed at excluding part of the population from control of the machinery of country. It may be economic, in a variant of territorial control relating in this case to dispute over resources. It may also be cultural or social, between sections of the population occupying very unequal positions in the structure of society which prevent upward mobility and condemns one section to remain subordinate to another, without hope of change. These sections of society are often clearly identifiable most often through ethnicity, religion or tribe (UNDP, 2000).

Ethno-political and religious conflict nearly tripled between 1945 and 1989. Although systematic cross country evidence is rare, one study classified 233 politicised communal groups in 93 countries according to political, economic, and ecological differences and found that most groups suffering horizontal inequalities had taken some action to assert group interests, ranging from non-violent protest to rebellion (Gurr, 1993). Currently, various conflicts in the world, particularly developing countries' internal conflicts are

dominated by ethno-political motivation (Dunaway, 2003). To obtain power, politicians are known to use ethnic and religious background as a means of gaining political support. This often leads to violent conflict.

Ethnic and religious conflicts, political violence and wars that presently shape conditions in many parts of world have deep-seated structural causes. For example, in poor countries, economic and environmental decline, assets reduction and erosion of the subsistence base lead to further impoverishment and food insecurity for vast sectors of the population (Pedersen, 2002). Population may be divided along cultural or religious lines, by geography, or by class. The group differences have many dimensions; economic, political, and social. Relatively privileged groups may also be motivated to fight to protect their privileges against attack from relatively deprived groups (Stewart, 2002). Moreover, many groups of people who created violent disputes in the areas where they live, perceive themselves as belonging to a common culture (ethnic or religious), and part of the reason that they were fighting might have been to maintain their cultural autonomy.

The violence in North Maluku Province was largely religious in character, while that in Central Kalimantan Province was seen as largely ethnic in nature. However, although religion in North Maluku became an important factor in the later stages and ethnicity in Central Kalimantan, in both cases it was fundamentally related to the government's highly political transmigration policy, described in sections 1.7.1 and 1.7.2.

The following sub-sections examine the arguments for ethno-religious and political conflicts with emphasis on ethno-religious conflicts, as these are the main reason often given for conflict in Indonesia.

2.2.1 Ethnic Conflict

According to Weber (1968) an ethnic group is defined as a group of people who share one or more of the following characteristic: language, kinship, ancestry, race, colour, culture, religion, history and/or physical appearance. Within ethnic groups there is a potential to develop conflict, as Tellis and colleagues noted;

> *"conflicts as a result of competition over resources certainly could occur even within an ethnic group, but the primordialist assumption—that ethnic groups are characterized by strong forms of organic solidarity flowing from self-evident ties of biology, culture, or race—implies that such competition either would not be significant or would not result in large-scale violence directed at one's ethnic cohorts. Such significant, large-scale violence would almost by definition be directed primarily at other ethnic groups, justifiably or not, for reasons connected with the larger competitive – tribal - constitution of society " (Tellis et al., 1998: 19).*

Ethnic conflict is defined as a form of identity conflict that takes place on a regional level between two or more ethnic groups; SCONA noted that

> *"ethnic conflict, like other forms of internal conflict, is created by the existence of discriminatory political institutions, exclusionary national ideologies, inter-group politics, or elite politics. Ethnic conflict refers to situations where people mobilize against others on the basis of ethnic identity" (SCONA, 2005).*

Power relationships between communities cause ethnic conflicts, also tension over control of valuable or scarce natural resources in the areas where the different ethnic groups are settled are a potential trigger for conflict (Gokcek, 2002).

Ethnic conflict entails a clash of cultures. It pits against each other people whose values are in conflict, who want different things, and who do not really understand each other. Ethnic conflict is a persistent feature of modernity but the last decade has brought seismic changes in the relations between scores of ethnic communities around the world (Aklaev, 1997). Ethnic conflicts may be brought on by economic development and modernization, which might exacerbate pre-existing conditions of inequality (Tellis *et al.*, 1998; Kaufmann, 1996). Disputes over land and the natural resources belonging to the local ethnic population may constitute one of the main causes of conflict, particularly if the local economy was previously marginalised while the incomers benefit from the land and the natural resources.

As noted in section 1.7.1 the 2001 violence in Central Kalimantan Indonesia can be understood as the continuation and accentuation of a pattern of resistance by the Dayaks to Jakarta's policies of fostering economic development and national integration through population transfers from Java island to the "under populated" outer islands (transmigration). While Dayak leaders cite cultural clashes with the Madurese as the reason for the violence, the Dayaks' animosity toward the newcomers was no doubt

fuelled by the economic and social marginalization of the Dayak people under the regime of New Order. For the past two decades the government has granted permits to logging and plywood companies and commercial plantations. The Dayaks lost most of their land to timber and mining concessions. Dayaks were also poorly represented in public organizations such as the army, government, civil service and police. The violence by Dayaks against the Madurese was thus rooted in the systematic marginalization of the Dayak community (Smith, 2005).

Over the five years preceding the conflict, tension increased between the Dayak and Madurese communities as new waves of migrants and temporary migrants from Madura flooded in. Following the conflict in 2001, this group faced increasing integration problems. Not only did they speak only their own language, Madurese, but they never completely left their homes or families on Madura Island (Smith, 2005). The control of the informal sector of the economy in urban areas in Central Kalimantan by Madurese, particularly in Sampit town, also appeared to have hampered their integration with the other migrant and Dayak groups. Sources in Central Kalimantan said that the way Madurese ran the markets in urban areas led to a fear of the Madurese, further isolating them from the rest of the community (Global IDPs, 2004; Achwan *et al*., 2005; Smith, 2005).

Dayak communities felt increasingly marginalized in their traditional lands during the transformation of much of the region to a commercial plantation and logging system. Claiming traditional land rights under the New Order regime had been difficult. In the lead up to the conflict they felt it was only the migrant groups who benefited from public social and economic resources of the province. They felt excluded from government development programmes and health, education and other public services, which tended to be concentrated in the urban areas where most of the migrant groups had settled. Furthermore, the Madurese were senior in the military and a Madurese had formerly been Head of the regional parliament. Thus, in both political and economic terms, the Madurese appeared more threatening to Dayak interests than the other groups (Smith, 2005).

Ethnic violence in Central Kalimantan has had economic, demographic and social impacts. Trade, consumption and production all decreased, according to small business holders in Sampit town. Most traders and port workers and the majority of the informal economic sector had been Madurese. Unemployment also rose following the conflict, according to local sources. The economic impact of the departure of the Madurese coincided with a government crackdown on illegal logging. The local health system was disrupted by the conflict and it appeared that there was no effective government in many rural areas of Central Kalimantan Province (Smith, 2005).

Ethnic conflict is often the result of mobilization of ethnic groups by ethnic entrepreneurs or elites pursuing private interests and capitalizing on the availability of ethnic networks –i.e. ethnically defined groups. Elites may also socially construct ethnic identities or reinforce racial, religious, or linguistic cleavages in such a way as to produce new sources of friction and conflict (Sambanis, 2001: Gokcek, 1996). These identities or cleavages may not be an accurate reflection of history, but are presented to the target groups in such a way as to inflame feelings, giving control to those who seek to gain power. Although several factors contributed to the conflict in Central Kalimantan however, ethnic conflict was prominent in that area.

This situation was also aggravated because the Indonesian security forces were stretched to their limits in Aceh, Irian Jaya and Maluku, leaving little spare capacity to contain the seething ethnic resentments in Kalimantan (Carey, 2001). This situation resulted in the failure of the security forces to prevent the prolonged conflict.

Indonesia consists of many ethnic groups; ethnic conflicts have occurred in several regions in recent years, and the probability is that they will continue to trouble governments and communities.

2.2.2 Religious Conflict

'Religion is a major source of soft power' (Reychler, 1997). Religion is often considered a key component in any community and continues to be an important aspect of the community social life. It can be a source of hope, social support and a means of coping with whatever situation is presented (Salzer, 2006).

Religious practices and beliefs have often been at the centre of conflicts throughout history. Religious conflict can involve two or more completely different religions or can rip apart one religion from within (Metcalf, 1999). Religious beliefs are so deeply engrained into cultures that conflicts arise with change or when different religions come into contact (ibid). The number of religious conflicts has escalated since the beginning of the Cold War.

According to Fox's estimates (2004) throughout the 1950-1996 period, religious conflicts constituted between 33 and 47 percent of all conflicts. Moreover, since the end of the Cold War, the rate of purely religious conflicts has decreased in relation to non-religious conflicts (Fox, 2004). Increasingly, religion is both an identifiable source of violence around the world and simultaneously deeply interwoven into other sources of violence. While certainly not a new phenomenon, religiously motivated violence has become a pervasive element of modern conflicts (Treverton *et al.*, 2005). It is Bertrand's (2004) view that religious conflict is mainly the violent expression of grievances that use religion as a basis of group identity.

Even if the differences are minor, followers of all religions can become fervent when threatened. In short, religion is something worth fighting for, according to history. However, possibly one of the greatest ironies is that religious conflict usually goes against the teachings of the religions involved (Metcalf, 1999). In addition, religious extremists can contribute to conflict escalation.

Increased attention to the role of religion in conflicts has been stimulated by positive and negative developments including the desecularisation of the world and the rise in the number of religious conflicts (Hunter, 1991). For example, religion is now used as a means to further divide and segment an already sensitive mix of populations such as several in Central Asia (Ahmedova and Leitich, 2001) and South East Asia.

The increase in religious conflict in many parts of the world, particularly in some parts of Indonesia, has triggered hatred between followers of some religions. The religious conflict in Maluku and North Maluku through the experiences of Malukuan Christians and Muslims differed markedly in the late colonial period (Chauvel, 1985). Christians were favoured for political position under the Dutch colonial administration. This preferential treatment ceased with the arrival of the Japanese during World War II, who tended to favour Muslim groups. However a relatively peaceful coexistence had been maintained though a system of traditional beliefs emphasising ethnic similarities rather than religious differences (WHO, 2001).

The conflict in North Maluku was preceded by an event in 1975, when the population of Makian Island, south of Ternate Island, threatened by the eruption of a volcano, was offered transmigration to a region south of the town of Kao on the north-eastern coast of Halmahera Island. This meant that the exclusively Moslem Makians were resettled in the Kao District because of fears of volcanic eruptions on their island. Almost the whole population of nearly 30,000 people chose to move; in theory for a temporary period. This area became known as Malifut after the main village in the area. Ironically the eventual volcanic eruption was minor and very little material damage occurred – those who returned to the island found their houses intact (Global IDPs, 2001a).

Initially, the local Kao residents welcomed the new arrivals into the community. However, the abrupt insertion of so many people from another ethnic group led to disputes about ownership of land and control of resources, which in theory still belonged to the people of Kao. The Makianese are Muslim whereas the Kao people are predominantly Christian; this added to the conviction in the Christian communities that the Government was trying to change the balance of power in Halmahera through

transmigration of Muslims. A number held and continue to hold senior positions and therefore have much influence in the affairs of the Province. On a negative note, the Makianese considered the neighbouring villages lazy and the Kao consider the Makianese arrogant and "trouble makers" (WHO, 2001; Wilson, 2004).

On 18 August 1999, the former Indonesian President Habibie created by decree the new sub-District of Malifut, sectioned out from the Kao sub-District in North Maluku. On the same day, the regency administration of North Maluku was about to formally inaugurate the establishment of a new sub-district (*kecamatan*) called Malifut as decreed by the central Government Regulation No 42/99. According to this regulation, the proposed new district would consist of 16 Makianese villages, which were predominantly Moslem, five Kaonese villages and six Jailolonese villages. The latter groups of villages are predominantly Christian. Under the 1999 decree the ownership of all land and resources, including the gold mine, was apparently allocated to the Makianese without compensation to the Kao people. In addition to this, and almost considered worse, four mixed but mainly Christian villages from Kao and six from Jailolo were included in the new sub-district. Confrontation was almost inevitable. Both the Kaonese and the Jailolonese villagers refused to be included in the new district of Malifut since they would clearly be the minority in their ancestral land. Conversely, the Makianese settlers insisted that the regulation be implemented without further delay. The inauguration ceremony was postponed indefinitely for security reasons. Violence then started to take its own course (Tomagola, 2000; Mawdsley *et al.*, 2002).

In addition to these political factors, an Australian company discovered gold in the early 1900s in the area of the dispute. The two communities strived to make sure they were the ones to benefit most from the operation of the gold mine (Tomagola, 2000). The discovery of gold in Malifut was a factor, which, with its attendant strife, added another component to the already complex picture. Another factor of major interest was that related to land. The Makianese felt that after devoting so much energy to working the land that it was now "their land" by right; whereas the people of Kao considered that they had been extremely generous in "lending their land" to the Makianese. The land

had been for hundreds of years their ancestral land and they were determined that it would remain so (Alhadar, 2000; WHO, 2001).

The surge of violence between the 24th of October and the 9th of November 1999 was very considerable with large scale damage to property, public facilities and houses. All 16 villages of the Makianese settlers were levelled to the ground. In terms of the loss of human lives and casualties the Moslems suffered more than the Christians. The Moslem Makianese men who had been driven out arrived in Tidore and Ternate islands. They were deeply frustrated and angry; they did not wait long. Upon their arrival they started to attack Christians both in Tidore (on the 3rd of November) and in Ternate (between the 6th and the 9th of November 1999). In Tidore, a Protestant priest was killed and several Christians injured. In Ternate, in addition to many casualties, several churches were burned down as well as the homes of many Christians (Tomagola, 2000).

2.2.3 Political Conflict

Behind these ethno-religious conflict issues, a main contributor to the conflict was the seeking of political power and resources. According to Marshall

> *". the term "political conflict" can have many different meanings depending on the context in which it is used; the appropriate measurement of political conflict depends upon meaning and context....political conflict (i.e, conflict between groups) is usually distinguished from social conflict (i.e., conflict involving individuals in a social context) and inter-personal conflict (i.e., conflict between individuals) by reference to the inherently political nature of social group organization (Marshall, 2001: 1).*

There are wide variety of types of struggle, conflict within states, between classes, religions, ethnic groups, and tribes, often as result of inequalities in access to political power and decision making, as well as in securing resources for development; and struggles between states over territory, some of which relate to the often arbitrary way in which historically colonised countries and their borders were defined (Zwi *et al.,* 1999). The degree of conflict varies from country to country and horizontal inequalities are most likely to lead to conflict where they are substantial, consistent, and increasing over time (Stewart, 2002). At a local level, access to employment, housing and other necessities for daily life can add to perceived inequality, so contributing to conflict.

Toole and colleagues and Zwi observed that modern conflicts are increasingly internal rather than between countries and often have, as a prime objective alongside the quest for economic and political power, the undermining of the lives and livelihoods of civilian populations associated with opposing factions (Toole *et al.,* 2001; Zwi, 2004).

Complex political emergencies are not isolated events but linked with globalisation, and foreign policies of the countries (Zwi *et al*, 2002; Duffield, 2001). Economic, political, social, and technological globalization have created new challenges to the state, such as exploitation of the natural resources by multi-national companies and the free market. Sondorp and Zwi also mention that

> *"these too often forgotten crises are complex political emergencies, a term that underlines the political nature of these internal wars, with their complex origins and multiplicity of players"* (Sondorp and Zwi, 2002: 310).

Crawford also argues that

> *"the current worldwide round of ethnic and sectarian violence is ironically linked to the apparent triumph of economic globalization and institutional transformation—the opening of new markets for goods, services, capital, and people; the construction of new democracies; and the implementation of "state-shrinking" ideologies that have swept the globe"* (Crawford, 1998: 2).

The causes of political conflict may be material or even spiritual. For example, in Aceh Indonesia, local Acehnese believed that political conflict in that area caused by the political system created by the previous regime was designed to benefit central level in terms of natural resources. On the other hand, the Acehnese apply a spiritual law to run the province which differs from the law of the rest of the provinces in Indonesia.

As noted in the previous sections, political issues contributed to the conflict in Central Kalimantan. Dayak communities felt increasingly marginalized from government development programmes and were excluded from political decision making which tended to be concentrated in the urban areas where the most of the Madurese had settled. Moreover, the Madurese played a greater role in the regional parliament than the Dayaks. As noted previously, political issues also contributed to the conflict in North Maluku

province, particularly a political decision taken at central level to create a new sub-district, which fuelled the religious conflict in this province.

As Holdstock and Jarquin argue

> *"modern conflict is not an expression of innate aggression but an economic and social construction. It is an attempt to settle, by violence, disputes over political power, territorial and ethnic issues, and social stresses such as injustice and poverty"* (Holdstock and Jarquin. 2002: 345).

Another contributory factor for complex emergencies was the weak sense of nationalism of the people in the country, because of the political power being concentrated in the central level where there was a lack of ethnic representation. As Chirot and Seligman pointed out

> *"strong nationalism reduces internal ethnic differences. On the contrary, where nationalism is weak and the state does not take strong measures to foster it, all kinds of internal cultural differences, ranging from linguistic to religious to merely regional can become a primary focus of identity and lead to internal ethno-political warfare"* (Chirot and Seligman, 2002: 15).

In some parts of Indonesia, particular groups in the population are struggling with the weakness of their nationalism. Considering that the country consists of many different ethnic groups, the unity of Indonesia is a fundamental ideological issue. Unity is challenged by secessionist groups in several places, particularly those in the eastern part of Indonesia. This situation has the potential to create new conflicts in the future within the social structure of much of the Indonesian population.

2.3 General Consequences and Impact of Complex Emergencies

The consequences on a population of complex emergencies are enormous: the impact is felt primarily within the conflict zone but extends to the neighbouring regions, provinces and even countries. Consequences of complex emergencies may be similar for both refugee and IDP populations (Global IDP, 2001a; Cohen and Deng, 1998).

In almost all complex emergencies, the forced displacement of population is a major event either within the country, as internally displaced persons, or across the borders of the country as refugees (Meek *et al*., 2000). According to the United Nations High

Commissioner for Refugees (UNHCR), the General Assembly resolution 428 (V) of 14 December 1950 defined a refugee as "a person who, owing to a well founded fear of persecution for reasons of race, religion, nationality or political opinion, is outside the country of his nationality and is unable or, owing to such fear, unwilling to avail himself of the protection of that country" (Lebanese NGO Forum, 2006).

The definition for an internally displaced person is similar. According to the Guiding Principles on Internal Displacement, internally displaced persons (also known as "IDPs") are "persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized border" (Representative of the Secretary-General on the human rights of IDPs, 2006). Concerns regarding IDPs have grown in the last decade as intra-state conflicts have increased. The number of IDPs has increased exponentially leading to a situation where IDPs outnumber refugees by nearly 2 to 1 (iDMC, 2007a; 9), with global figures of 25 million IDPs (ibid).

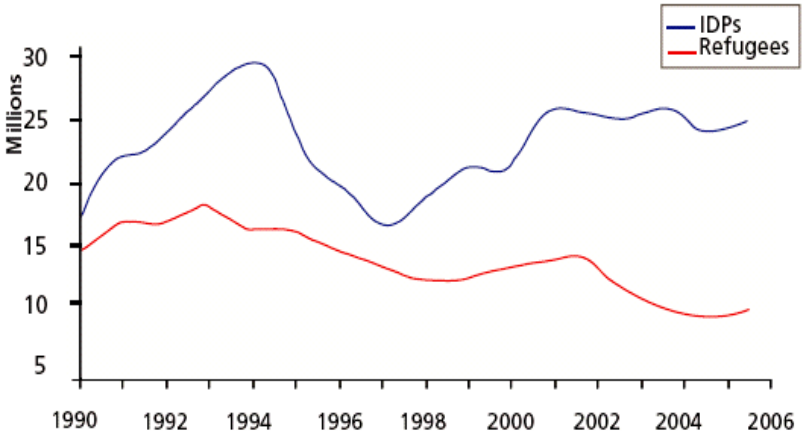
While the status of refugees is enshrined in the 1951 UN Convention Relating to the Status of Refugees and refugees benefit from an established system of international assistance under international law (Subramanian, 2002). IDPs rely on the willingness of their governments to acknowledge their situation and react responsibly to their needs without prejudice. Unlike the Refugee Convention, internally displaced people have only the voluntary guidelines established by the UN in 1998; Guiding Principle 3 of these Principles states that, "national authorities have the primary duty and responsibility to provide protection and humanitarian assistance to internally displaced persons within their jurisdiction".

Hence, the crucial difference between the two main types of displaced populations-refugees and IDPs - refers to which institutions have the main responsibility for the protection and assistance of a population displaced by an emergency – whether natural

disaster or complex emergency. This is particularly important in examining the nature of the response to the health needs of a specific IDP population, as the consequences of many displacements commonly focus on the health status and service provision for refugees which is largely provided by humanitarian agencies in countries neighbouring the conflict-affected countries.

According to UNHCR, at the start of 2005 there were approximately 19.2 million refugees. This was an increase of 13% from the 17 million refugees at the start of 2004. However, the number of refugees dropped from 19.2 million to 9.2 million by 2006. This was primarily due to the voluntary return of many refugees to Afghanistan and Iraq. Figure 2.2 below shows the number of IDPs and Refugees from year 1990 -2006.

Figure 2.2: Number of IDPs and Refugees (1990 -2006)
(iDMC, 2006a)



Sources: IDMC, USCR (IDP figures); USCR (refugee figures)

In contrast, the UNHCR estimated that there were 25 million IDPs in 2004, but the organization was able to assist only approximately 5 million. The countries with the largest populations of IDPs were: Colombia, Sudan, Azerbaijan, Liberia, Sri Lanka, the Russian Federation, Bosnia and Herzegovina, Serbia and Montenegro, Georgia, Afghanistan, and Cote d'Ivoire. The largest total population of IDPs in year 2006 was found in Sudan (5.35 million) (iDMC, 2007a).

Both IDPs and refugees experience very similar impacts on their lives including severe public health consequences mediated by displacement, food scarcity and the collapse of basic health services (Toole and Waldman, 1997). Those affected may often be resettled in temporary locations with high population densities, inadequate food and shelter, unsafe water and poor sanitation. These conditions have enabled communicable diseases, often in combination with malnutrition, to emerge as major killers (WHO, 2006a).

Generalised impoverishment also accompanies complex emergencies, interacting synergistically with health deterioration, with the following dimensions: landlessness, joblessness, homelessness, marginalisation, food insecurity, loss of access to common property assets and social disarticulation (van Damme *et al.*, 1996).

2.3.1 Consequences and Impact of Complex Emergencies in Indonesia

In Indonesia, with a background of government instability, hyperinflation, macroeconomic collapse, and elusive political solutions, these civil armed conflicts are likely to persist as complex emergencies (Bradt *et.al*, 2001). Complex emergencies are often exacerbated by natural disasters (Natsios, 1996), factors that are significant in the Indonesian context. Internal conflict in Indonesia in the last decade has resulted in the displacement nationwide of over 1.4 million persons. Since 1998, riots have killed more than 2,000 people, injured approximately 50,000, while more than 2,000,000 people suffered from traumatic stress and thousands of people were left homeless and vulnerable (Mulyadi and Agustiono, 2000).

During and after the riots in North Maluku, the IDPs, many of whom were Christians, moved into exile in the North Sulawesi province where in 2002 there were 36,667. In 2003 21,755 IDPs in North Sulawesi were resettled across the province and were distributed over the districts and municipalities (Global IDPs, 2004). The IDPs were housed in temporary accommodation in several government buildings in Manado as well as in warehouses in Municipal Bitung. In Minahasa, Bolaang Mongodow and Sangihe Talaud districts the IDPs lived with their relatives. The data shows that in North Sulawesi Manado hosted the largest number of IDPs, with a total of 11,804, compared to

other district and municipalities (Provincial Government Sulut, 2002). In 2002 the situation in North Maluku Province was gradually becoming tolerable and the IDPs in North Sulawesi decided to return to their province, helped by the Government and NGOs. However many other IDPs from North Maluku would not return because they were traumatised or because their property had been destroyed.

The outburst of ethnic violence in Central Kalimantan in February and March 2001 forced some 100,000 persons to flee to East Java and the adjoining island of Madura (Elmquist, 2001). According to the local government in Sampang District, 88,501 displaced Madurese arrived in the district there in 2001 (District Government Office Sampang, 2003). In 2003 in Central Kalimantan Province the situation was still unfavourable for IDPs to return to their homeland, and there were also many who would not return because they were still traumatised or had no property there.

In responding to the complex emergencies, and realising the difficulty of handling the impact of the complex emergencies, the Government of Indonesia established a Board at National level namely *Bakornas PBP* (The National Coordinating Board for Disaster Management and Internal Displaced Persons). This unit is a non-structural entity designed to promote coordination in managing disasters and internal displaced persons. *Bakornas PBP* is directly responsible to the President (Ngoedijo, 2003). The structure of organisation of *Bakornas PBP* can be found in Appendix A (WHO/OCHA, 2002). Similar units were established at different administrative levels:

- at the Provincial level, *Satkorlak PBP* (Task Force for Implementing Disaster and IDPs Mitigation) is a non-structural entity directly responsible to the Governor. The primary task of *Satkorlak* is to coordinate the response to disasters in all phases at the Provincial level. Its main function is to develop guidelines; develop cooperation with neighbouring provinces; report to *Bakornas PBP* on a regular basis; and monitor the implementation of disaster response (Bakornas PBP, 2003). *Satkorlak* is composed of task forces of the institutions and services concerned such as health, search and rescue (SAR), army, police, social, public works, Indonesian Red Cross (PMI) and NGO's. The structure organisation of *Satkorlak PBP* can be found in Appendix B (WHO/OCHA, 2002).

- at the Municipal/ District level, the *Satlak PBP* (Task Force for Implementing Disaster and IDP Mitigation) is a non-structural entity directly responsible to the Head of Municipality or District (Ngoedijo, 2003). Municipal/District units, as front line organizations, can mobilize all related agencies in their respective municipalities/districts, sub-districts and villages as well as involve local community organizations. The primary roles and functions of *Satlak* are similar to the Provincial level Satkorlak. At district level, the *Satlak PBP* was chaired by the Mayor (Head of Municipal) or Bupati (Head of District) and had a task force at every sub-district level. The structure organisation of *Satlak PBP* can be found in Appendix C (WHO/OCHA, 2002)

In order to support the coordination activities, every public sector related to humanitarian activities was allocated a budget. For example public sectors involved with the task force such as Ministry of Social Welfare, Ministry of Health, Ministry of Public Works, Ministry of Defence and Ministry of Home Affairs made an allocation from their fiscal year budget to support the activities of every unit at every level.

Addressing the root causes of displacement is the only long-lasting solution to the difficulty of IDPs in Indonesia. The Government of Indonesia acknowledges the useful planning underway to address the plight of the IDPs. The government allowed the International agencies and NGOs to be part of handling the problems of the IDPs both in zone conflicts and recipient areas with their specific areas of expertise. NGOs in particular can work with the government to improve the temporary accomodation and provide support for long-term assistance (Refugee International, 2004).

The year 2003 was marked by a significant decline in the number of IDPs from 1.4 million to a maximum of 535,000 people by mid-2003 (CAP, 2004). As the numbers continued to decline, the Government announced that central funding for IDPs would no longer be available after 2003, and that the remaining IDPs should be reclassified as “vulnerable people” (ibid).

2.4 Consequences and Impact on Health Status of Affected Populations

Complex emergencies have a major effect on a population and increase the level of human needs because they impact directly and indirectly on basic human requirements, including health. The direct impact of conflict on health comprises both increased morbidity and mortality, including that from external causes mainly related to weapons; from infectious diseases (e.g. measles, malaria); death from non-communicable diseases and those avoidable through medical care (e.g., asthma, unavailability of emergency surgery) (Waldman, 2001).

A wealth of evidence has accumulated over the past 25 years on the massive effect of war on public health. Displaced persons typically experience high mortality immediately after being displaced (Levi and Sidel, 1997). Excess morbidity, disability and mortality are due not only to the lack of essential public health and medical actions, but to the shortage of essential goods (water, food, shelter, sanitation, security, etc) for meeting vital needs, as well as to the inability to mitigate the effects of the determinants of health (biological, social, political, or economic) (WHO, 2000b).

As noted above, complex emergencies are linked with public health emergencies. Conflict frequently affects access to health programmes and services provided by the health authorities. Moreover, the consequences are often long-lasting for both IDPs and refugees. Ghobarah and colleagues note, for example, that:

> *"complex emergencies produce long-term damage to public health and medical systems that extend well beyond the period of active warfare"* (Ghobarah *et al.*, 2004: 869)

Noji (1997) identifies conflict as a public health problem because it may:

- cause an unexpected number of deaths, injuries, illness in the affected community, exceeding the therapeutic capacities of the local health services and requiring external assistance.
- destroy the local health infrastructures such as hospitals, which will therefore not be able to respond to the emergency. It may also disrupt the provision of routine health services and preventive activities, leading to long-term health consequences in terms of increased morbidity and mortality.

- have effects on the environment and the population, increasing the potential risk for communicable diseases and environmental hazards that will increase morbidity, premature death, and diminish quality of life in the future.
- cause shortages of food with severe nutritional consequences, such as starvation or specific micronutrient deficiencies – for example, vitamin A deficiency.

Abdallah and Burnham (2000) reported that in many emergency situations up to 80% of the affected population are women, children, and elderly persons. Displacement makes these groups more prone to violence, starvation and even death and increasingly vulnerable in number of ways:

· *Physiologically vulnerable* - resulting from lack of access to basic needs, including health care; e.g., pregnant and lactating women, young children, the elderly, and people who are malnourished or sick.

· *Socially vulnerable* - lack of access to education and social support, e.g., female-headed households, unaccompanied minors, AIDS orphans and the disabled.

· *Economically vulnerable* - lack of sufficient income, e.g., the poorest

· *Politically vulnerable* - lack of autonomy and have no control over their situation.

It is clear that the most immediate and direct impact of conflict in a country is significant population displacement. According to the Global IDPs Project this displacement takes many forms but always results in a situation that requires emergency assistance (Global IDPs Project, 2003).

The literature predominantly identifies a complex emergency as a public health emergency with two phases – acute (around the daily crude mortality rate of above or below 1 per 10,000 deaths per day) (Sphere, 2004) and post-emergency (this phase begins when the basic needs of the population have been met and the crude mortality rates are comparable to those of the surrounding population (McGinn and Purdin, 2007).

The displaced are usually isolated from social, material, and emotional support systems, which may make them more fragile and vulnerable to environmental adversities and social distress. Indirect effects such as disintegration of family and social networks, disruption of the local economies and exodus of the work force have profound implications on the health and well-being of survivors (Pedersen, 2002). Among forced migrants, IDPs are the most vulnerable. Refugees sometimes may be better off than IDPs, because once a border is crossed then international treaties and laws often apply to their treatment. This is not true for IDPs since, as explained above, a sovereign government needs to agree to the need for aid in what is considered an internal problem (Waldman, 2001). Indonesia recognized this and allowed international and humanitarian agencies to support the government in handling the problems of IDPs. However, other countries, such as Sudan have been more reluctant because of the international community demanding accountability (Human Rights Watch, 2007).

Increased morbidity caused by injury or illness also result from the same range of causes: external causes (e.g. weapons, landmines, sexual violence); infectious diseases, acute and chronic malnutrition and deficiency disorders (Zwi, 2004; Valderama, 2002). Post traumatic stress disorder (PTSD) associated with psychological persecution causes trauma symptoms such as flashbacks, memory disturbance, panic and sleeplessness in a significant proportion of displaced persons (Hines and Balletto, 2002; Ager, 1999). Outbreaks of cholera, dysentery, tuberculosis, acute respiratory infections and other viral diseases, such as measles and dengue are a frequent occurrence in displaced populations.

Other public health areas affected by complex emergencies include reproductive health and mental health. Reproductive ill health is of particular concern as there may be an increase in the number of stillbirths and premature births, more cases of low birth weight, and more delivery complications among IDPs. Pregnancy, sexually transmitted diseases, and AIDS are also on the increase among displaced persons especially women and adolescents who have experienced sexual abuse. Chronic illnesses that can normally be treated lead to severe suffering in the absence of treatment (Zwi, 2004; Connolly and Heyman, 2002; Toole *et al.*, 2001).

In the post emergency phase disease patterns are roughly the same as those in any non-displaced population. Diarrhoeal diseases, acute respiratory infections and malaria are the major killers and the most frequently encountered health problems. Others, such as reproductive health problems, AIDS, tuberculosis, mental problems may also account for a significant proportion of morbidity and mortality at this stage (MSF, 1997). In addition, epidemics of communicable diseases continue to occur: cholera, hepatitis, measles and meningitis (Aldis and Schouten, 2001). The Global IDPs Project noted that in complex emergencies the major health problems of displaced persons in recipient areas maybe similar in the post emergency phase. The most common conditions of IDPs (malaria, diarrhoea, measles, high blood pressure, rheumatic diseases, and heart conditions) occur at nearly the same rates as in the host community. In the case of IDPs, however, these conditions are often not treated adequately (Global IDPs, 2002).

Although cardiovascular, respiratory, gastrointestinal and psycho-neurological diseases are prevalent among displaced populations, infectious diseases accounted for the majority of incidence and prevalence of IDPs' health problems during the last five years. In Sudan for example, communicable diseases remain the leading cause of morbidity and mortality and the risk for epidemic diseases, such as malaria, dengue fever and meningitis were very high (WHO, 2006b). In Myanmar, the most common causes of death of IDPs were diarrhoeal diseases, acute respiratory infections, and malaria (BPHWT, 2006). Most deaths in displaced populations occurred among children under 5 years of age (Banatvala and Zwi, 2000). Disabilities related to injury are likely to require long-term health care, and unaccompanied orphaned children and pregnant women are especially vulnerable to a variety of diseases (ibid).

In Indonesia, at that time, epidemiological data was commonly incomplete for IDPs and refugees. A study by Bradt and colleagues (2001) for Ambon Maluku and West Timor showed that infectious diseases generally remained the leading causes of morbidity and mortality for IDPs and refugees and in these two areas. A report by Ambon Municipal Health Office in Indonesia gave the causes of illness of IDPs as acute respiratory

infection, malaria, diarrhea, pneumonia and measles (Bradt, 2000). In West Timor the leading cause of mortality in refugees was diarrhea and malaria (Bradt *et al*, 2001).

Salama and colleagues (2004) noted that there are three major constraints in reducing morbidity and mortality of displaced population in a complex emergency situation. First, both the epidemiological science and programmatic interventions need to go beyond the displaced population paradigm upon which much of the research was based and consider that all displaced populations are not necessarily the same. It is essential to explore the health status and needs of each particular group of IDPs so that the health programmes and services for reducing morbidity will minimise it and so mortality will fall.

Secondly, public health interventions in all settings must attain high coverage. Although high coverage rates for health and nutrition interventions are relatively easy to attain in situations of temporary accommodation, challenges can seem insurmountable when an affected population covers a large and insecure area. Poor access to health and nutrition services by IDPs may restrict the coverage and effectiveness of supplementary and therapeutic feeding programmes, despite dramatically reduced malnutrition-related case fatality rates inside the facilities.

Thirdly, there is a need to address the more distal underlying causes of complex emergencies, and thus work at the levels of primary and secondary prevention. In complex emergencies in both camp and non-camp settings, humanitarian interventions provide responses that are limited to the health and other social sectors; such interventions might minimise the consequences of societal disruption, but they cannot undo existing damage (Salama *et al.*, 2004).

This literature review demonstrates that the impact of complex emergencies on an affected population generally results in a decrease in their health status and increased health needs.

2.5 Consequences and Impact on Health Systems and Service Delivery

Health systems, as defined by the World Health Organization (WHO), comprise the organizations, institutions and resources that are involved in actions to improve health (WHO, 2000c). All three of these components are likely to be negatively affected by ethno-religious and political conflicts and the disruption that surrounds and follows them. Bornemisza and Sondorp confirm this and state

> *"…during a complex emergency, health systems are often severely compromised, and health policy formulation is disrupted"* (Bornemisza and Sondorp, 2002: iv).

The impact on health systems depends on the type of complex emergency and the health systems in place before the crisis, including in the recipient areas. Even in normal situations, most health care services in developing countries are insufficient to respond to the needs of the population and have no integrated emergency preparedness planning in their public health programmes (CERTI, 2000). As noted earlier, the primary responsibility for health service provision for a large internally displaced population falls on the governments of the recipient areas where displaced people have"settled". This is because the IDPs are regarded as part of the population of the country and the local government has to provide health programmes and services to them.This situation created potential burdens on the health systems of the recipient areas.

In the next section, the impact of displacement crises will be examined for their impact on the management and organisation of the district level, including district health resources, drugs, equipment and supplies, and healthcare financing, followed by a brief overview of the impact on service delivery.

2.5.1 Impact on Management and Organisation of M/DHO

As Toole and colleagues point out, district health organisations may rapidly become overwhelmed when a large number of IDPs suddenly move into an area and seek to use local health services. Their absolute number may exert an unsustainable burden on local health services (Toole *et al.*, 2001). Even if the local health sector of the recipient area tolerates the influx, problems may be anticipated if the IDPs extend their stay. There

may be problems in health management and in relation to components of essential health programmes and services; for example in planning and evaluation of health programmes for the IDPs (Waldman, 2001). Management and organisation of the recipient local health authority systems may change because of alterations to health policy.

The arrangements and regulation may have to take account of the change from a stable condition to an unstable one, particularly when IDPs first arrive. Organisers of the health sectors in the recipient areas may need to create new health system and policy (Waldman, 2001). The structure of the organisation will need to be reviewed in order to adjust to the changing situation, possibly by adding a division to serve the IDPs' health needs (ibid)**.** Additionally, it may become necessary to add specific health initiatives in order to provide health programmes and services for the IDPs, particularly necessary for those who wish to stay longer or decide later that they will stay and integrate with the host community.

2.5.2 Impact on Health Resources

Complex emergencies affect many health resources including those in the recipient area. Health resources provided for the host community may be affected in ways such as overburdening the health workforce; limited of health finance care; there may also be a shortage of drugs and supplies because of a large number of IDPs seeking health care.

i. Health Workforce Capacity

There is a direct impact on the health workforce of from the sudden influx of large numbers of displaced persons (Waldman, 2001). The arrival of IDPs in a recipient area creates an increase in the amount and extent of work for the public health workforce with no added recompense. As a result, health programmes such as communicable disease control activities may be seriously compromised; vector control, house spraying, environmental programmes, information and education, training and supervision conducted by the health workforce may all be overloaded (Waldman, 2001).

The unfavourable nature of most recipient areas also affects the motivation of the health workforce and is aggravated by a poor and uncertain salary (Rowley, 2006). There are several countries with experiences of the impact of complex emergencies. For example in Uganda many health workers have often been unwilling or unable to remain in the health centres and clinics to provide regular and effective medical care (iDMC, 2007b).

The capability and skills of the health workforce in the recipient areas might be weak because of lack of training in delivery of health programmes and services to large numbers of IDPs. However, it is possible that health workers would have to extend their roles when dealing with IDPs. This is particularly the case in poor recipient areas or isolated municipalities/districts that have difficulty recruiting and retaining health workers. WHO (2007) suggested strengthening the management of health systems through training (particularly in-service) directed at restructuring, upgrading and streamlining the available workforce, before their deployment.

ii. Drugs, Equipment and Medical Supplies

Conflict and displacement places constraints on finances, logistical organisation and security and puts severe limits on the quality of care that can be provided. This may mean that a particular intervention will neither be effective in meeting health needs, nor cost-effective. In these circumstances, choices have to be made as to whether a particular service component should be provided (WHO, 2000d). Additional problems may emerge as a result of humanitarian response. Drug donations, if poorly co-ordinated and standardised, may lead to a large number of expired and inappropriate drugs being off loaded in countries. They may be unable to be used, but must be safely and efficiently disposed of; again placing an additional burden on the recipient country's pharmaceutical resources (Toole *et al.*, 2001).

Quality of health service may suffer greatly. Health care technologies, including x-rays and laboratories, are undermined though lack of maintenance, spare parts, skilled personnel, chemicals, and other supplies (Toole *et al.*, 2001). In the areas that have received IDPs, the budget for health services requires to be increased especially for the

purchasing of drugs, supplies and equipment. However, it can be assumed that the local availability of drugs and supplies in the recipient areas might be based on the needs of the host community. This would be affected by the huge number of the IDPs who, because of their low health status, need drugs and supplies as well.

iii. Healthcare Finance

Healthcare finance is a means of achieving policy objectives (Poletti, 2003). Healthcare finance has two main functions:

- *Managing risks:* a good health care finance system can act to manage risk and mitigate its consequences by pooling risk
- *Mobilizing funds:* ensuring that resources can be made available where and when they are needed and subsidising the vulnerable (ibid).

According to Ranson and colleagues (2007) there is little in the peer reviewed literature on the impact of user-fees in the context of conflict-affected areas. However, three key drivers of catastrophic payment that have been identified for developing countries— the necessity of payment to access health services, low capacity to pay, and the lack of prepayment or health insurance — are all present in conflict-affected areas (Ranson *et al*, 2007: 7). According to Toole and colleagues (2001) commonly, at least in the short term, these local recipient areas will receive no additional resources including fincance and will therefore have to cope as best they can with the additional demand of the IDPs.
Healthcare finances in recipient areas are influenced by the number of incoming IDPs. Sources of healthcare finance in order to support the needs of IDPs on the other hand may be inadequate particularly in areas with limited local resources. Without an adequate financial scheme, health programmes and services to support IDPs' health needs cannot be fully implemented by the health authorities in the recipient areas.
In order to cope that particularly situation Sondorp and Zwi suggested:

> *"management of health workforce and finance are invariably issues that must be speedily addressed in a system so dependent on the quality and motivation of its health workers"* (Sondorp and Zwi, 2002: 311*).*

2.5.3 Impact on Provision of Health Service Delivery

The nature of a conflict and its complex emergency consequences varies from region to region within countries, and even from one moment to the next in the same region. Health systems in the conflict areas can be challenged by post conflict recovery. Those in the areas that receive IDPs faced other problems. In practical terms, this means health services are affected in different ways, particularly in the provision of health service delivery.

There is increasing recognition that conflicts have a significant negative impact on health services delivery in the conflict areas as well as in the recipient displaced population areas. Increased numbers of people in a particular area constitute a large burden on local health services. In addition the IDPs' health condition may be poor, especially if their journey has been traumatic and unplanned (Toole *et al.,* 2001). They also present opportunity, however, for the development of new services; the challenge of confronting adversity allows for innovation, creativity, and the emergence of new technologies that may have some positive benefits for health (Zwi *et al.,* 1999). The primary responsibility for health service provision for a large internally displaced population falls on the government in the host areas where a displaced population has "settled".

IDPs at high risk are required to be provided with life saving health services. Health services make available the means for providing the tools and supporting the strategies needed to battle communicable diseases. These services are required to provide good quality health care that is affordable, accessible, equitable and relevant to the needs of the displaced populations. However, challenges for health services delivery include how to prioritise, implement and coordinate service provision, taking into account issues of equity and limited access (Hecker and Sax, 2002).

The State's inability to raise revenues, or the low level of importance attached to heath services by the government may make the provision of quality health services unattainable (Forum MDG, 2005; Barnabas and Zwi, 1997). In addition, lack of political

support means that policy makers and politicians do not push forward an active agenda for health services.
Lack of revenue and political will can threaten health services even for a host community, therefore a displaced population will be at an even greater disadvantage in obtaining health services.

Provision of health services delivery may be affected in a variety of ways, particularly in the recipient areas. For example, as new IDPs arrive, the health service delivery by the recipient area will be focused more on the IDPs because their condition makes them more susceptible to disease. Overburdening of the primary health care programmes and public health services increases the morbidity and mortality rates in IDPs (Waldman, 2001). Furthermore, the health services delivery will shift from primary to secondary care, which is hospital based care, concentrating on the large influx of IDPs living in overcrowded conditions in the host areas (ibid). The provision of health services, health programmes or public health interventions to the host community could be directly affected. The recipient areas are likely to experience a shortfall in the provision of health services because of the large numbers of IDPs arriving at the same time. Moreover, the quality of health services would be affected.

The impact of the conflict induced changes in health services maybe described as decreased accessibility and availability of services leading to increased levels of infectious diseases (Toole and Waldman, 1997). Access to health services is limited in countries where governments either have ceased to function effectively or intentionally obstruct aid effort (WHO, 2000a).

Host communities may be willing to accept the arrival of IDPs in their area, but if the IDPs extend their stay and become competitors in each sector including health this may generate hostility and tension between the two communities.
A confluence of political and environmental factors such as natural disaster exacerbates the lack of access to basic health care making the IDP group more vulnerable (Salama *et al.,* 2001). Other reasons why IDPs are unable to make more use of public health

services delivery are related to supply and demand. The demand side is particularly weak owing to the poverty of IDPs and the supply side is the public institutions providing the health services. For example, the demand of IDPs can be for information on health care (choice of provider), or related to their economic status, or their need for health education. The supply factors are the high cost of services, low quality of service, health care providers' lack of knowledge, lack of technology and inefficient management of staff (Ensor and Cooper, 2004).

In the complex emergencies (CEs) situation, access to health services and appropriate services provided either by public, private or NGO providers are in high demand by the people affected by CEs. WHO (2004) noted that the IDPs, who have chosen not to be repatriated, may find themselves in a legal vacuum. They may no longer be protected by the local host government nor may they be fully protected as citizens of the host provinces or municipality/district. The IDPs may not be eligible for health services on an equal footing with the recipient areas' community. For example, the IDPs may have to pay for health services without being protected by the policy exemption for the local municipality/district.

2.6 Response to Health Needs Resulting from Complex Emergencies of Government of Indonesia

IDPs are amongst the most vulnerable people in the recipient areas and the local government in these areas is required to be responsible for their protection and health. The response of the Government of Indonesia to IDP crises was outlined in section 2.3.1.

Related to the health programmes and services provided by the DHO and *puskesmas* for IDPs, the M/DHO were required to synchronize and report to the local government through the Executive Coordinating Unit for Disaster Management and the Handling of Displaced Persons (*Satkorlak PBP*) at province level and *Satlak* at Municipal/District level (Bakornas PBP, 2003).

The government particularly at the Ministry of Health created a policy and national strategy for complex emergencies and guidelines on how to coordinate with other divisions within the MoH and related sectors working in the zone of complex emergencies as well as in the recipient areas. The purpose was to minimise the risks, particularly health of the IDPs (MoH, 2001b).

Of considerable impact on the M/DHOs dealing with the IDP crises was the government decision that, due to the declining number of IDPs after 2003 (CAP, 2004), central funding for IDPs was to be no longer available and that those IDPs who remained in the recipient areas were to be re-classified as "vulnerable people" (ibid). The experiences of IDPs in relation to their health status and access to health services, and that of the M/DHOs in Manado and Sampang in coping with this decision were investigated in this study.

The experience of the recipient M/DHOs in Manado and Sampang is examined in much greater detail in later chapters.

Conclusion

Complex emergencies produced through various causes such as ethno-religious and political differences create displaced populations and massive destruction. IDPs are among the most 'at-risk' in this vulnerable population. Individual and differing groups of IDPs have different levels of vulnerability to various types of conflict and its impacts, due to poverty, gender, age, social, economy, ethnicity or religious identity.

Individual health services, and the health system as a whole, similarly have differential degrees of vulnerability (Griekspoor *et al*., 2002).

In these situations it may be seen that health needs of IDPs increase during the acute stages of displacement, with increased morbidity, disability and mortality rates. In addition, as the extent, form, intensity, and severity of violence varies, so will its effect on health systems and health services. Consequences of complex emergencies also have a direct impact on recipient municipalities/districts. Health systems are severely stretched or become fragmented by the arrival of IDPs from the conflict areas.

Challenges to health service delivery include difficulty in prioritising, implementing and co-ordinating the service provision, taking into account the issues of equity and limited access.

Access to the health services in recipient areas is influenced by socio-political and geographical factors which can reduce the utilisation of public sector health services and health facilities by IDPs. Furthermore, social disturbance, resulting from conflict of interests between IDPs and host communities, may occur in areas that receive IDPs and this can limit access to the health services.

For the most part, the literature considers the effect of ethno-political and religious conflicts in the conflict areas but there is limited information about the effect of ethno-political and religious conflicts in areas that receive IDPs, particularly the impact on health systems. In general ethno-political and religious conflicts increase the risks to the population involved regarding their health status or security as well as the development of the country, municipality or district either in the specific area of the conflict or in the IDP receiving area. In addition, it is clear that the term complex emergency was coined to capture the nature of the crises it faced and the multifaceted, comprehensive response required.

The next chapter will focus on a literature review of health needs, determinants of health, the elements that comprise health systems and health decentralisation policy.

Chapter Three

Health Needs, Health Systems and Health Decentralisation Policy

Introduction

This chapter presents firstly a literature review of the health needs of the population, health systems and health decentralisation policy; beginning with an overview of the determinants of health. In addition a consideration of the concept of health systems and health decentralisation policy, with specific reference to developing countries and particularly those affected by complex emergencies, is given.

The literature chosen for review encompasses health systems and health decentralisation policy in both normal and complex emergency settings. The special focus is on those operating in post-conflict situations. The review explores the particular elements of health systems and services that address or attempt to address the needs of IDPs, particularly in recipient areas where there are large numbers of IDPs. This is important because IDPs are a particularly vulnerable population in terms of health issues and are still a persistent aspect of the situation in Indonesia.

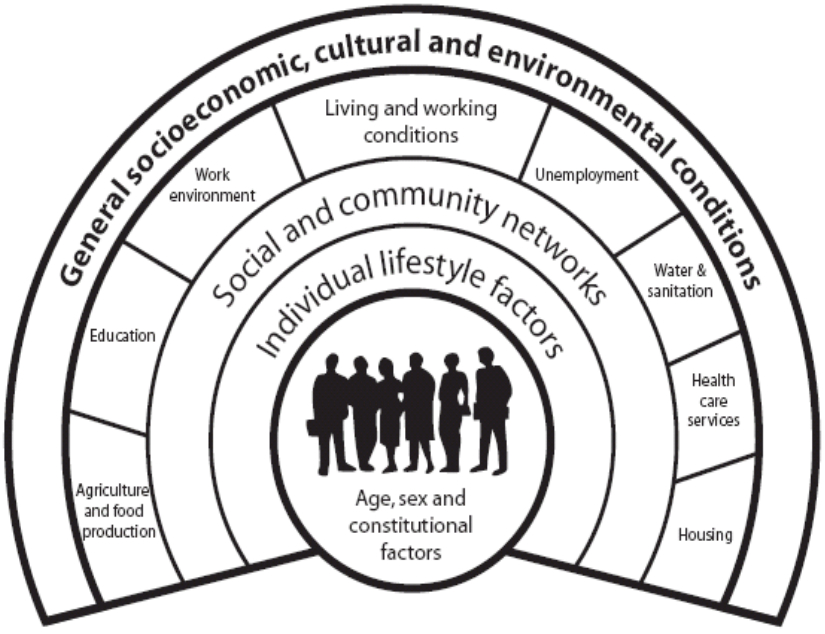
3.1 Concept and Determinants of Health

Before moving to a discussion of health needs, an understanding of the concept of health and the determinants of health is important. The World Health Organisation's definition of health is often used: Health is a state of complete physical, psychological, and social wellbeing and not simply the absence of disease or infirmity. A more romantic definition would be Freud's: Health is the ability to work and to love (Wright *et al.*, 1998). Health is defined as a positive concept that emphasises social and personal resources, as well as physical capabilities. It involves the capacity of individuals – and their perceptions of their ability – to function and to cope with their social and physical environment, as well

as with specific illnesses and with life in general (Baggott, 1994). Health is a social and cultural concept in addition to its fundamental biological characteristics. There are three basic sources of differences in the health of populations: hereditary determinants, socio-economic circumstances, life styles and behavioural factors. Gender differences span all three domains as do cultural and political factors (Beaglehole, 2004).

The determinants of human health status are broad, extending from genetic influences to the social, cultural, educational and economic environment and include manifold pathways by which the various factors operate to influence health status at both population and individual levels (Marmot and Wilkinson, 1999). Figure 3.1 depicts the determinants of health based on the model of Dahlgren and Whitehead (1991), which suggests that there are complex, multi-layered influencing factors with an impact on the health of individuals.

Figure 3.1: Determinants of Health
(Dahlgren and Whitehead, 1991)



At the centre are factors including age, gender and genetic inheritance. The effects of genetic factors on the various components of health and the ageing process are not yet well known. It has been estimated that only 20 to 25 percent of variability at the time of death is explained by genetic factors (Christensen and Vaupel, 1996; Weissman, 1996). Major research into the genetic causes of disease is worldwide; every year advances are made, leading to the hope that in the future many current health problems will be curable or preventable, thus improving the health status of the population.

Gender differences in health status are apparent throughout the life span and one expression of this is the feminisation of later age, where women account for the bulk of the over-60 population in almost every country of the world (ILO, 2000; Beaglehole, 2004). Gender may influence health status in the following ways such as exposure, risk or vulnerability, ways in which symptoms are perceived, health seeking behaviour, access to health services and ability to follow advised treatment. According to Prus and Gee (2003), differences in health status between men and women may also be associated with differential exposure to socio-economic status, stress, social support and lifestyle characteristics.

In the second layer are life style factors and behavioural patterns such as physical activity, diet and smoking. Health related behaviors are determined by whether individuals perceive themselves to be susceptible to a particular health problem; see their health problem as serious or not; are convinced that health prevention and services are effective and are exposed to a cue to take a health action (Elder *et. al*, 1999). Physical exercise, diet control, self-care practices, social contacts and work style are important contributing behavioural factors to health status.

In a third layer are consisting of social and community networks. Social interactions are increase the life span and allow for faster recovery from diseases. Many studies now are trying to determine how social interactions bring about beneficial hormonal and genetic changes that increase the quality and length of life.

Socio-economic circumstances, such as levels of educational attainment, employment, occupation and work environments, income, social support, family patterns, housing and living conditions as well as community safety are major health determinants that shape the health status of individuals and populations (Wright *et al.,* 1998; Marmot and Wilkinson, 1999; Berkman and Kawachi, 2000). Unemployment, social exclusion, transport and food are aspects of social determinants of health (Stevens, 2005). There are significant social class differences in height, growth, and other aspects of physical development, as well as in the incidence of infectious and other diseases and risk of injury (Wardsworth, 1997). In certain populations and areas, poverty, economic inequality and poor social conditions exceed mortality and morbidity in creating issues of concern to public health.

Education, which often reflects socio-economic circumstances and is often measured by duration of schooling, has been shown to have an important correlation with health (Grossman and Kaestner, 1997). There is evidence that better education can, through general improvement in literacy and health knowledge, increase desire for, and use of, health services (Ensor and Cooper, 2004). Education also contributes to health by equipping people with the knowledge and the skills for problem solving, and providing them with a sense of control over life circumstances (Marmot and Wilkinson, 1999). In addition, education is perceived as important for acquiring new knowledge about cultivation, income generation, health and social affairs (CECI, 2000). However, education can have a very limited effect if resources such as time, access, opportunity and facilities are unavailable.

The fourth layer includes the wider or underlying determinants, agriculture and food production, education, work environment, living and working conditions, unemployment, water and sanitation housing.

In the outer layer are the socioeconomic, political, cultural and environmental conditions present in society as a whole (HDA, 2005). Culture and ethnicity derive from both personal history and wider situational, social, political, geographic and economic factors

(PHAC, 2002). Cultural factors can have positive and negative influences on health. People with strong family, cultural and community ties have been shown to have better health than people who are socially isolated (NACHD, 1998). However, some cultures and ethnic groups refuse to make use of modern health technology.

Health is profoundly political in a number of ways. Political decision-making shapes social and economic environments and health systems and has important effects on the health of populations. Policies involving the organisation and delivery of health services, social safety nets, insurance programmes all influence health status (Beaglehole, 2004), particularly as health resources are unequally distributed in society (Bambra *et al*., 2005). Health's "social determinants" such as housing, income, and employment, are critical to the accomplishment of individual, family, and community wellbeing and are themselves politically determined. Health is recognized by many throughout the world as a fundamental right, yet it is irreparably intertwined with our economic, social, and political systems. And growth in health, health care, and health systems requires political debate and political consensus (Bambra *et al*., 2005).

In sum, all these determinants of health help to maintain the health status of a population in a stable environment. However, they can lose much of their effect when that population becomes displaced. The break up of social relationships, sudden economic disruption and the impact of unfamiliar cultures in recipient areas can increase health needs. This research focused on some determinant health factors in order to explore the health needs of the IDPs.

3.2 Health Needs

Health needs incorporate the wider social and environmental determinants of health (Wright *et al.*, 1998). The definition of need is related to the requirement for specific necessary elements of services (Stevens and Gillam, 1998). It is essential to consider each dimension of need to increase the chance of constructing a comprehensive picture of community problems. Bradshaw (1972) suggested four different types of need.

a. Normative need

Normative need refers to what expert opinion, based on research, defines as need. For example, the National Health and Medical Research Council in UK recommends all children aged 12 - 15 months be vaccinated against measles. If data show that many children are not immunised, this indicates a health need.

b. Expressed need

Expressed need refers to what can be inferred about the health need of a community by observation of the community's use of services (e.g. long waiting lists, demand for a new service). Expressed need can however be misinterpreted by an observer. Long waiting lists for a health service may be the result of inefficiency and not about the size of the group wanting to be treated. Additionally, a need may exist but because there is no service in place to meet it, the expressed need may not be identified.

c. Comparative need

Comparative need is derived from examination of the services provided in one area to one population and using this information as the basis for determining the services required in another area with a similar population. When assessing comparative need the level of service provision in the reference area must be appropriate in the first place. It is necessary to be aware that data collected may be a reflection of over-servicing or under-servicing by service providers rather than an indication of true need for the service by health consumers.

d. Felt need

Felt need refers to what communities say or feel they need. Common methods of assessing felt needs are household opinion surveys, phone-ins, public meetings and calling for submissions from those in the community. When determining felt needs there are three things to note:

1. People have a tendency to express needs in terms of a solution e.g. more nursing home beds.
2. People may be representing themselves or others.
3. The level of expectation in relation to services may influence felt need.

There are several dimensions that need to be considered in an assessment of perceived health need. People at risk, people with health problems and providers of services can all identify needs for services where the services are matched to or fulfil their needs (Peoples-Sheps, 2001). Another area in which assessment of perceived needs is very important is in identification of barriers to the use of services. Barriers may be related to the means by which the services are delivered, to cultural beliefs, to geographical circumstances or to unfulfilled expectations of the type of health service delivery.

In determining health needs it is necessary to include accommodation, health service, finance, education and transport (Asadi-Lari and Gray, 2005) because these factors are also part of determinants of health. To meet health needs equitably requires an understanding of cultural variations among population subgroups, and adaptation of services (NHS Executive, 1995). Raine and colleagues (2003) also argue that the need for health care depends on the ability to benefit from health care facilities, meaning that those who need health care should be able to access health facilities to obtain health services.

People's health needs are dynamic not static, therefore continuous monitoring and evaluation of health programmes and services is important in order to fulfil the health needs of those who are in need. Musgrove argued that:

> *"in a perfect health system health needs for health services would generate a demand for appropriate service, and the supply of services would meet every demand. There would be no difference between giving people what they need and giving them what they want, and also no under–or-over supply of health service" (Musgrove, 1995: 2).*

Moreover, Wright and colleagues state that "scarcity of health resources available to meet health needs is often differentiated as needs, demand and supply". Need in health care is commonly defined as the capacity to benefit. In this research 'capacity to benefit' is from the treatment. According to Murray and colleagues capacity to benefit from treatment has four dimensions. One is the degree of functional improvement and/or symptom reduction obtained if treatment is successful. Another is the probability that the treatment will be successful. A third is the number of years that the patient gets to enjoy

the benefit and the fourth the statistically expected number of gained quality of adjusted life years or both quantity and quality of life generated by healthcare interventions (Murray *et al*, 2002). Demand is what patients ask for. Supply is the health care provided and will depend on the interests of health professionals, the priorities of authorities, politicians, and the amount of money available" (Wright *et al.,* 1998: 1311). However, in real health systems, need, demand and supply often do not coincide and overlap (Wright *et al.,* 1998; Musgrove, 1995*).*

A displaced population is exposed to new health risks: food insecurity, poor quality of water and sanitation, overcrowding in temporary settlements, exposure to infectious agents and vectors for which they lack immunity. IDPs and refugees are particularly vulnerable because they are facing these risks and, having lost employment, assets and social networks become in most cases, completely dependent on aid (WHO, 2007b). The IDPs could express which particular or specific health programmes and services they expected. The health needs of the IDPs are taken as their ability to benefit from the services provided. Waldman noted

> "*health needs of the IDPs are different in every stage of CEs"* (Waldman, 2001: 1427).

The health needs of the IDPs in the acute phase of complex emergencies are different from the IDPs in the post emergency situation. This situation is underlined by the health authorities' response to the needs of the IDPs.

IDPs perception of their health needs and their desire to benefit from health services requires knowledge and skill on the part of those responsible for providing those services and identifying the necessary health priorities.

In answering the research questions 'felt need' was considered to be particularly important in examining the health needs of the IDPs, while not neglecting the significance of the other categories of need.

3.2.1 Health Needs Assessment

Health needs assessment is a systematic method for reviewing the health issues facing a population. This allows agreement on priorities and resource allocation that will improve health and reduce inequalities (HDA, 2005). In order to measure health needs a measure of health status is required that is based on a concept of health such as the definition by WHO that health is total physical, mental and social well-being (Bowling, 2005), and regard the health determinants as factors that influence health status.

Assessment of health status is the foundation step for the entire planning process for providing health programmes and services in the health system. The first step involves careful specification of the dimensions of a problem and analysis of its precursors. For example, because IDPs are vulnerable people it would be important to understand what particularly caused illness and the contributory factors to that illness. In the second step, the focus shifts from health problems to health services (Peoples-Sheps, 2001). A health service needs assessment examines the adequacy of existing services to prevent a problem by tackling its precursors or compensating for their effects (ibid). In this research, this meant that health programmes and services offered to the IDPs, including health policy, are based on IDPs' health needs.

Need has been quantified using various conceptualisations including those pertaining to heath status, social vulnerability, and capacity to benefit from intervention (Percy-Smith, 1996). Approaches to health needs assessment can focus on a speciality (for example mental health), a disease, a client group, groups seeking interventions, and vulnerable groups (ethnic minorities, IDPs and patients who are socially deprived) to address issues of inequity. Both physical and psychological needs reflect the need for health care services.

Information about perceived need can be gathered though a variety of means, many of them qualitative. Data collection methods include individual interview, focus groups, direct observation and population based survey (Peoples-Sheps, 2001). Moreover, information about diseases or use of health services can help to build up a picture of the

health need of the population interested. Such epidemiological information can come from national, regional or local sources (Wright and Walley, 1998). Using several methods in order to analyse the health needs of vulnerable people to produce different kind of evidence is very important in order to make sure that the data are valid in supporting the recommendations. McEwen and colleagues observe:

> *"'there is no single best method of assessing health needs - different issues and questions require different methods and approaches and degree of detail and different combinations of professionals to be involved"* (McEwen *et al.*, 1995:179).

Hensher argues that conducting research to establish health status in a specific population related to specific health needs is difficult:

> *"measuring 'health status' remains heavily contested technically, methodologically fraught, very expensive and very hard to conduct even in ideal research sites"* (Hensher, 2001:5).

The "health status" indicators for the respondents of this survey, despite the potential number of potential risk factors, were limited to morbidity and mortality rates; morbidity was used as a proxy for analysis of the health needs of respondents considering that it would allow the researcher to assess the respondents illness' and explore their access to and utilisation of health services.

Fundamentally, an understanding of a population's demographic and socio-economic characteristics is essential to identifying health needs and planning health programmes and services. These social indicators represent important population characteristics that can have related health attributes; for example, age, education, occupation, ethnicity, religion, household composition and structure (Wright et al., 1998; HDA, 2005). These indicators were applied to this research.

In sum, health needs assessment is about gathering knowledge and understanding about how healthy or not is the population of interest. This assessment is important because it can review the health issues facing a population of interest, and agree priorities and resource allocation that will improve health and reduce inequalities (HAD, 2005).

Information may be obtained in different ways to describe the health of particular age groups by looking at specific disease groups, e.g. malaria, or by looking at population groups, e.g. displaced persons; or the particular locations in which the population of interest lives. As mentioned in Chapter One, Manado and Sampang differed in their geography, topography, and status of area. Manado is a municipality and Sampang a rural district. Moreover, the epidemiological profile and percentage of poor people including those with access to water and sanitation was much lower in Sampang than in Manado.

The approach to assessing health need used in this study is described in more detail in Chapters Four and Five.

3.2.2 Identifying Health Priorities

Without priorities and a common focus it is virtually impossible for a health authority to achieve results. Identifying health priorities for health improvement is essential, but it is also a challenge. The process of choosing priorities is at the heart of the health assessment process (HDA, 2005). In choosing priorities, the impact of adverse health conditions on the population and their determinants need to be considered, and communities and health service providers need to work together to identify and determine health priorities.

Health priorities may be identified from either the profile of the important aspects of health conditions or health status and their determinants in the target population or a national health priority in the country, identified without population profiling (HDA, 2005). Identifying health priorities may also be done by considering the relative priority of each service according to: 1) the prevalence of the precursor to which the service is addressed; 2) the strength of the relationship between the precursor and the problem; 3) the extent of unmet need for the service and; 4) other relevant service characteristics, such as effectiveness and acceptability to target groups (HDA, 2005).

Identifying health priorities in a situation of unmet needs requires creative skill as much as scientific capability from health researchers and health officers in health authorities. Clearly, it requires a good understanding of health problems, the nature of the health services, and the political decision making in the context in which the public health systems exist.

3.3 Health Systems

Health status is influenced by the determinants of health, as mentioned in the previous section, and health systems available in the area where the people live. A health system consists of all the activities whose primary purpose is to promote, restore or maintain health (WHO, 2002c). Identifying health status in order to understand the health needs through health need assessment and set up health priority programmes and services for a target population of interest is a part of health system activities.

According to Roemer (1991) a health system is a combination of resources, organisation, financing and administration that culminates in health services offered to the population. WHO defines a health system as all the organisations, institutions and resources that are devoted to procuring health actions. A health action is defined as any effort, whether in personal health care, public health services or through inter-sectoral initiatives, whose primary purpose is to improve health (WHO, 2000c).

Health systems currently face challenges unlike those they have ever faced before (Evans *et al.*, 2005). Around the world governments face pressures to provide health services effectively, efficiently and equitably. Reforms in both developed and developing countries have adopted similar approaches to getting health systems to perform better: downsizing, privatization, competition in service delivery, performance measurement and indicators and community participation (Brinkerhoff, 2003). Additionally, health authorities need to know how to influence the health-seeking behaviour of target groups in need of care.

Health systems consist of all the people, available resources and actions whose primary purposes are to improve health, and include everything involved in improving the health of a community. Murray and Frenk (2000) defined the goal for a health system as "…to improve the health of the population. A second goal for health systems is fairness in financial contribution. A third is responsiveness to people's expectations in regard to non–health matters, such as reflecting the importance of respecting people's dignity, autonomy and the confidentiality of information" (Murray and Frenk, 2000: 717). The way health systems are designed, financed and managed therefore affects people's lives and livelihoods (SIDA, 2002). Health systems are the means whereby health programmes and services are planned by the public and private health sectors and delivered to the community.

Health systems vary greatly from country to country as well as province to province and municipality/district to municipality/district. This is especially true of a large country such as Indonesia that consists of thousands of islands. This research examined two different areas in Indonesia, an urban municipality and a poorer rural district.

Countries' health systems, particularly in developing countries, vary in size, organisation, and level of development and capability to perform effectively and efficiently (Bathia and Mossialos, 2004).
A health system needs staff, funds, information, supplies, transport, communications and overall guidance and direction (WHO, 2005). Resource availability, particularly health workforce capacity, is fundamental to a functioning health system (Millennium Project, 2005).

Two criteria frequently used to judge health systems are efficiency and equity. Efficiency has a number of different dimensions: macroeconomic efficiency refers to the total cost of a health system in relation to overall health status. Microeconomic efficiency refers to the scope for achieving greater efficiency from existing resources (Mills and Ranson, 2001). Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one

should be disadvantaged from achieving this potential if it can be avoided (Whitehead, 1990). Equity refers to the distribution of the cost of health services and the benefits obtained from their use between different groups in the population. It can be expressed in two different ways. Horizontal equity refers to the equal treatment of equals and vertical equity is based on the principle that individuals who are unequal in need should be treated differently (Donaldson and Gerard, 1993).

According to the UN Millennium Project (2005), health systems can be a vehicle for fulfilling rights, for active citizenship and for true democratic development – poverty reduction in its fullest sense.
A health system is said to have met the needs of the population for which it is responsible when it meets the professionally defined need of all groups including those who are not in a position to translate their need into demand (WHO SEARO, 2005).

Health systems have a responsibility not just to improve people's health but to protect them against the financial cost of illness and to treat them with dignity (WHO, 2000c). Through an appropriate health system the health needs of vulnerable people will be met.

3.3.1 Municipal/District Health Systems

The municipality/district health system is the core of health development in the country (Segall, 2003), where the health programmes and services are provided to the local community, vulnerable people as well as IDPs through the elements of the health system. WHO (1998) stated that it comprises first and foremost a well-defined population, living within a clearly delineated administrative and geographical area, whether urban or rural.

A municipal/district health system is concerned with identification of priority health problems, strategies, goals, most important services and necessary materials to provide them, supportive management mechanisms in planning and control (MoPH RoY, 2003). According to Roemer (1991) there are five major categories that enable a comprehensive description of all health system whether at central or lower levels (municipality and district). The categories are:

Production of resources (trained staff, commodities such as drugs; facilities; knowledge);

Organisation of programmes (by governments, ministries, private providers, voluntary agencies);

Economic support mechanisms (sources of funds, such as tax, insurance, user fees);

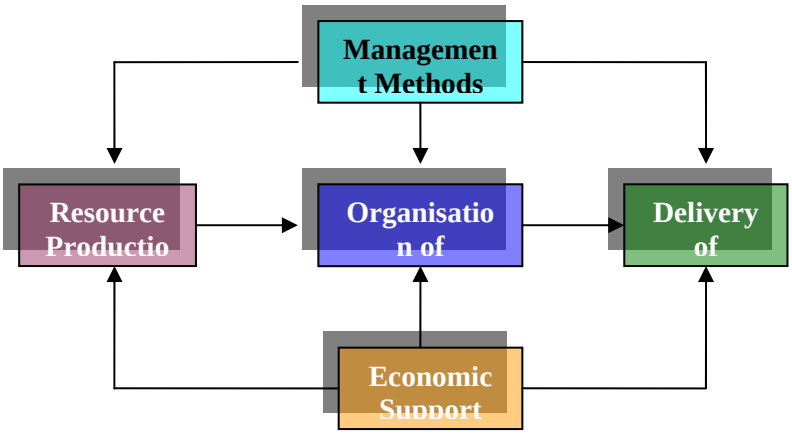
Management methods (planning, administration, regulation, legislation);

Delivery of services (preventive and curative personal health services; primary, secondary, and tertiary services; public health services; services for specific population groups, such as children, or for specific conditions, such as mental illness) (Roemer, 1991).

As shown in figure 3.2, health system elements closely interact with each other.

Figure 3.2: The elements of health systems

(Adapted from Mills and Ranson, 2001)



The categorisation above is helpful for describing health systems and this research analysed every element of the municipal and district's health systems. However, it is not helpful in understanding how health systems behave in terms of efficiency and equity (Mills and Ranson, 2001). This research used each of the above elements in order to approach the health systems at municipal and district levels.

According to Sambo and colleagues (2003) assessment of the district health systems involves the review of the organisation and management of the systems in terms of their structures, managerial processes, priority health activities, and the availability and management of resources.

Municipal/District health systems are more than just a structure or form of organisation. They are the manifestation of a set of activities that includes community involvement, integrated and comprehensive health care delivery, inter-sectoral collaboration and a strong bottom-up approach to policy development and management. McCoy and Engelbrecht argue that:

> *"the district or municipality management structure is supposed to be the point and level at which different service activities are integrated into a comprehensive and holistic approach to health care. For example, community based and facility based-health activities would be implemented as different components of a single health plan for a given population and area"* (McCoy and Engelbrecht, 1998: 1*).*

Integration and syncronisation of health programmes through coordination within the divisions and sub-divisions in M/DHO, hospital and community health centres are important in order to provide better health services to the population. Information from community and health facilities regarding health programmes and services is a potential data source in order to set up guidance and policies to develop the health programmes and provide services.

Delivery of health services is determined by the health system. Formal health services, including the professional delivery of personal medical attention are clearly within these boundaries (WHO, 2000c). Delivery of health services refers to the combination of the organization of programmes, management and economic support including health resources that culminates in the delivery of population-based services. Elements of the health system are also responsible for promotive, preventive, curative and rehabilitative population based services and are part of a municipal or district health operation or services provided to the community. This includes IDPs who live there temporarily or those who are willing to settle in the recipient municipality/district.

3.4 Indonesia's Health System

As stated by the Ministry of Health (MoH), the Indonesian national health system or *Sistem Kesehatan Nasional* (SKN) is an organisation involving the integration and mutual support of the various sections of the Indonesian nation and is dedicated to ensuring the highest health status. This mission is a realization of the general welfare specified in the preamble to the 1945 Constitution[•]. The principles of the health system in Indonesia are claimed to be humanity, human rights, justice and equity, community empowerment and autonomy, partnership, priority and efficiency, and good governance (MoH RI, 2003a).

The objectives of the SKN are the implementation of a vigorous, effective and efficient health development utilizing the entire nation's strength, the government as well as the community and including the business world, in order to achieve the highest community health status (MoH RI, 2003a). However, the health system in Indonesia is far from reaching this goal as the difficulties caused by escalating demand and limited resources are exacerbated institutionally by the implementation of the decentralisation policy and politically, by the ethno-religious conflicts in several provinces. In addition, the health system in Indonesia is currently influenced by its health decentralisation policy.

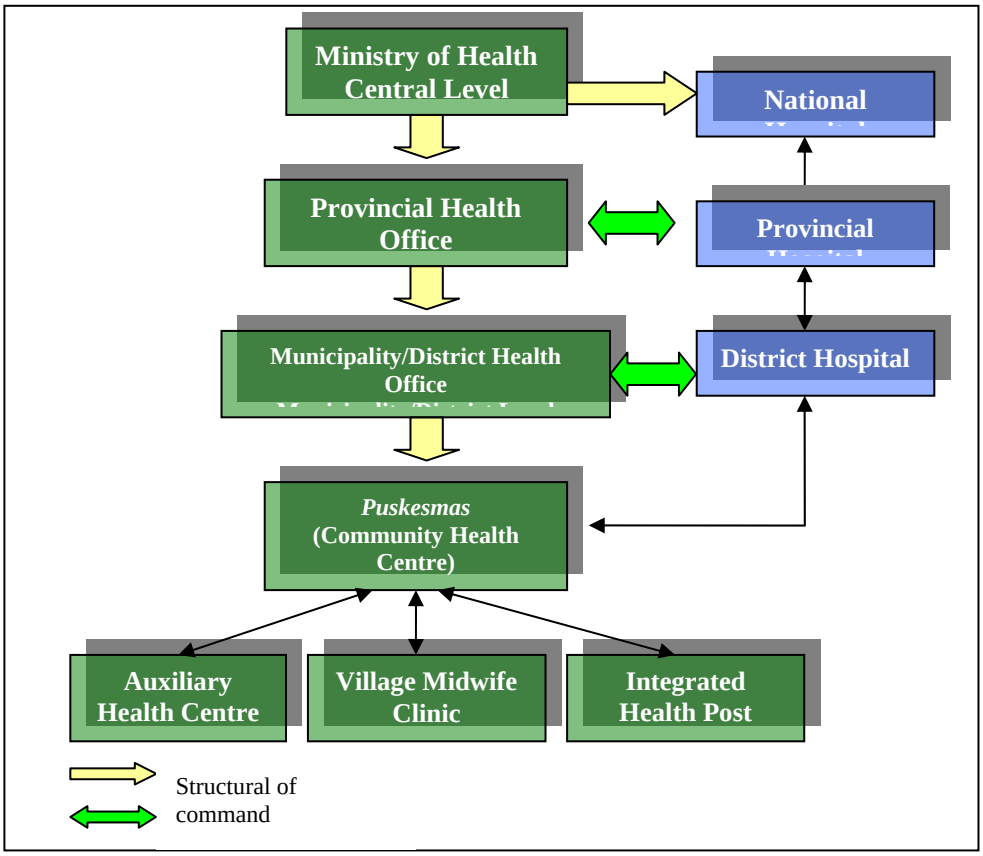
3.4.1 Health System Organisational Structure

In 1999 a reorganization of central level, provincial, municipal and district health offices was undertaken in the run-up to the decentralisation process. The aim was to increase the quality of technical and operational guidance to local health services. The technical policy determined by the MoH was translated into provincial and municipal/district policy to meet specific provincial and municipal/district considerations and needs. "Bottom-up" planning was encouraged through coordination meetings at each managerial and service level within the province and municipality/district.

[•] The Constitution of Indonesia (Indonesian: *Undang-Undang Dasar Republik Indonesia 1945, UUD '45*) is the basis for the government of the Indonesia. The constitution was written in July and August 1945, when Indonesia was emerging from Japanese control at the end of World War II. It was abrogated by the Federal Constitution of 1949 and the Provisional Constitution of 1950, but restored on July 5, 1959.

Figure 3.3 (below) illustrates the overall organisational structure of the health system and referral system in Indonesia.

Figure 3.3: Indonesia's Structure of Health System and Referral System



The Municipal/District Health Office (M/DHO) is an operational unit of the local municipal/district government under and being responsible to the Head of the municipality/district. The main functions of the M/DHO include implementation of all community-based health programmes; preparation of an annual health plan, supervision and control of all community health workers in the municipality/district; raising additional local funds; collection and compilation of routine health information and forwarding it to both provincial level and the MoH; and management of its subsidiary government health facilities (WHO, 2002).

In Indonesia, there are three levels in the clinical health system. Primary level includes the *posyandu* or integrated health post, the *pustu* or auxiliary health centre and *puskesmas* (Community Health Centre). Secondary level is the district hospital which gives backing to the primary level. It has in-patient beds and can provide surgical, obstetric and gynaecological, paediatric, and internal services. For referral purposes, each district had a district hospital, although a municipality does not always have a municipal hospital. Each province has one provincial health hospital (usually in the capital city of the province). Indonesia has two national hospitals in Java Island as the tertiary level in the clinical health system.

Each sub-district has at least one *puskesmas* usually with two or three satellite auxiliary health centres, the majority of which are headed by nurses. Most *puskesmas* are equipped with four-wheel drive vehicles or motorboats to serve as mobile health units and provide services to underserved populations in urban and remote rural areas (WHO, 2000a). The *puskesmas* provide basic or essential health services such as primary-level medical treatments (including emergency treatment), antenatal and postnatal care for women, family planning consultation, immunization and several other basic health services (MoH, 1992).

The *puskesmas* is headed by a medical doctor and supported by paramedical staff, administrative staff and support staff. The Head deals mostly with implementation of the health programmes for the communities and oversees the management process of the institution, including epidemiological monitoring and reports; pharmaceutical services and management of materials, finances, personnel and equipment. The *puskesmas* staffs also have responsibility for MCH, health environment, basic medical treatment and immunisation. Immunisation programmes offered by the public sector especially for infants and children are the Bacillus Calmette-Guerin (BCG), Diphtheria Pertussis Tetanus (DPT), Polio, Hepatitis B and Measles vaccines.

The health programmes and activities carried out by the *puskesmas* also include nutritional surveillance, environmental sanitation, communicable diseases control, health

education, school health, sports health, public health nursing, occupational health, oral and dental hygiene, mental health, eye health, simple laboratory services, recording and reporting, services for older clients and traditional medicine (Lieberman and Marzoeki, 2001).

The allocation of resources, as well as decisions on the kind of services to be provided by *puskesmas*, is part of overall district planning (Görgen *et al.*, 2004). In implementing the health programmes, the *puskesmas* are supported by a network involving auxiliary *puskesmas*, mobile *puskesmas*, and village midwives' clinic. A simple health facility unit under the *puskesmas* that covers two to three villages is called a *pustu*. A mobile health services unit (car or motor boat) equipped with a car, health and communication instruments, and health personnel is called a *Pusling*. In remote areas not reachable by the formal health services, a *Pusling* replaces the function of *puskesmas*.

In an effort to reduce infant and maternal mortality and reduce the number of pregnancies, the MoH set up an integrated service post called a *posyandu* (Leimena, 1989). At the village level, the *posyandu* provides scheduled preventive health services. These *posyandu*s are established and managed by the community with the assistance of *puskesmas* staff. The *posyandu* provides five basic services: MCH, nutrition, family planning, immunization and diarrhoeal disease control with technical assistance and guidance from *puskesmas*. The *posyandu* is a monthly activity, oriented towards mothers and children under five and attended by mothers, children and staffed by community volunteers, staff from the health centres, and/or family planning fieldworkers. The services that the *posyandu* offers depend on whether *puskesmas* staff attends at that particular time. If health workers are present the post may provide some prenatal and postnatal examinations, immunisation and injections, in addition to vitamin and nutritional screening and oral contraceptives.

The village maternity clinic is where the village midwife, equipped with an obstetric kit provides antenatal care, reproductive health and birth care to women in villages. There is a maternity hut in those villages that do not have other health services. The village midwife is provided with a cottage where she lives and works.

In order to reduce the infant and under five mortality rate the the MoH set up the infant and under five health card, namely healthy development monitoring cards. The cards is used in the *posyandu* to record details and monitor the growth of individual infants, their nutrition and the time schedule for immunisation.

In 2003, in line with transferring regional autonomy to municipalities/districts in Indonesia and in order to ensure that local governments would not neglect basic services to the community, the central government required them to implement obligatory functions to protect the constitutional rights of individuals and the community through established Minimum Service Standards (MSS•) in the Health Sector in Districts/Municipalities. Outside those services, certain municipalities/districts must deliver certain services according to local needs which include among others occupational health services, health services for the elderly, prevention and control of malaria, leprosy and filariasis.

In Indonesia, political structures have a stronger influence than health structures in determining health decisions. Table 3.1 sets out the relationship between the political position and the health structures from central level to sub-district level.

Table 3.1: Political position and related health structures in Indonesia (WHO, 2000a).

Political Structure		**Health Structure**	
Level	**Position of authority**	**Level**	**Position of authority**
Central	Government of Indonesia	Ministry of Health	Minister of Health
Provincial	Governor	Provincial Health Office	Head of Provincial Health Office
Municipality/District	Head of Municipality/District	Municipality/District Health Office	Head of Municipality/District Health Office
Sub-district	Head of Sub-district	*Puskesmas*	Head of *Puskesmas*

• Minimum Service Standard (MSS) is a performace and quality indicator of the standard service provided by the public health sector. The MSS for health covers a variety of services, providing the performance indicators on essential health programmes and services (MoH, 2003b),

3.4.2 Health Resources

The Municipal/District Health Office (M/DHO) needs to make the most effective use of all available resources to achieve better health. This includes both human and financial health resources. These resources are seen to be crucial in improving health services in Indonesia.

i. Human Resources

In 2003, there were 37,531 doctors or about one doctor per 6,000 to 7,000 of the population. They included some 11,000 specialists, 9,177 dentists and 7,646 pharmacists, distributed throughout Indonesia. There were about 233,166 registered nurses with varying levels of education, while the number of registered midwives was around 61,000; 80% of the midwives were located in the villages. Hence it meant that nearly all villages in Indonesia had midwives (MoH RI, 2005b). There were registered public health workers with varying degrees of expertise, including 13,912 public health administrators, 11,000 health environmentalists, 10,685 nutritionists and 28,255 medical technicians. The total number of health workers employed by the Ministry of Health and Regional Government throughout Indonesia in 2003 was about 450 thousand, 300 thousand being central government employees. Of the rest, about 100 thousand are regional government staff (ibid).

In Indonesia, health services are not equitably distributed throughout the geographic areas. For example, in several provinces such as Papua, Maluku and East Nusa Tenggara there are few medical doctors, particularly in rural areas. Most doctors are concentrated in urban areas. Moreover, measured in terms of the percentage of people within a specific distance in kilometres of the health facilities and the average distance to a hospital there are substantial variations in the access patients have to health care facilities. Urban areas are of course better served and have better health care access than rural areas. Similarly, there are large differences in the level of health care funding between urban and rural areas.

ii. Essential Drugs and Other Supplies

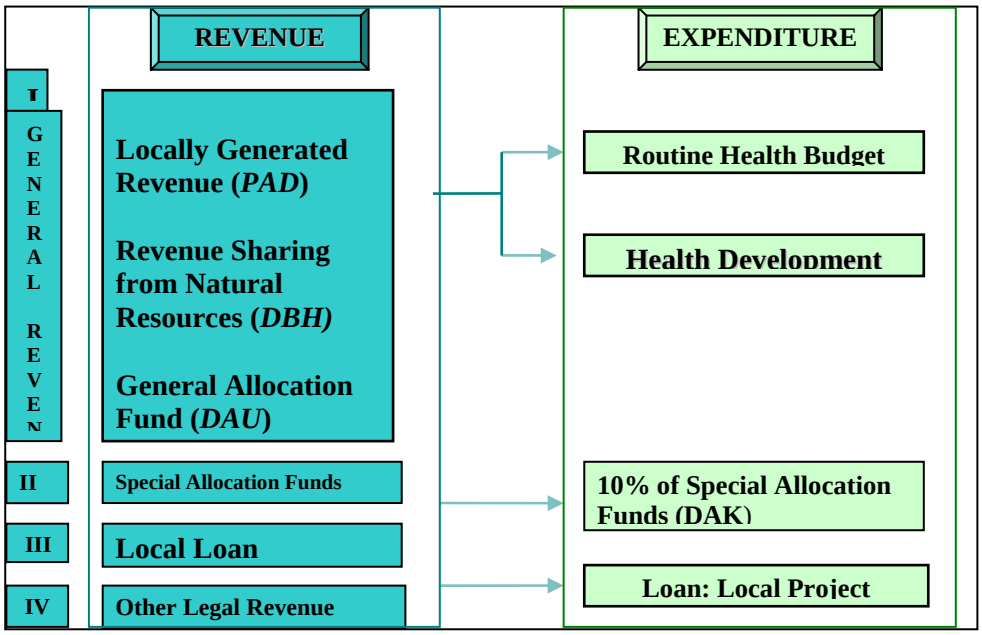
Following implementation of the national essential drugs list in public health facilities throughout the country and interventions made for the rational use of drugs, there has been a considerable decline in the excessive use of antibiotics, multi-drug combinations and injections. In 1995 a sample of remote facilities was found to have about 45% of the drugs listed. It was observed that allocations made for drugs are increasingly used for life-saving drugs, particularly for children. The proportion of *puskesmas* experiencing shortages of drugs has increased (WHO SEARO, 2005).

To ensure the availability and timely supply of high quality essential drugs at low cost, public owned companies have been designated as the main source of supply. The production of generic drugs is now done by four public and 26 private pharmaceutical companies. Essential drugs for the public sector are subsidized by the government and the price of drugs for use in hospitals and *puskesmas* is also controlled. The main constraints are the lack of understanding and suspicion by the community about the quality of generic drugs, the irrational use of drugs that still prevails among service providers, and the limited budget (WHO SEARO, 2005)

iii. Financing Health Care

The provision of health services in Indonesia is highly subsidised by the government. It is funded from various sources ranging from taxes to loans and grants from the private sector. Funding for health development in the Municipal and District Health Offices comes from several sources including central, provincial, municipal and district level budgets also from fees for services. Health finance from community resources was limited to the cash paid by individuals (MoH, 2003a). The fee tariff for services differs between municipalities and districts. It depends on local regulations discussed between local government and local legislative. Figure 3.4 show the municipality/district's financing.

Figure 3.4.: Municipal/District Health Financing
(MoH RI, 2003b)



Locally-generated revenue (PAD) is revenue raised by local government from local sources including local taxes and fees for public services.

Revenue sharing from natural resources is sharing of the pool of funds available from central government to achieve equalisation between Central and Local Government. The allocation of natural resources revenue distributes it to the different levels of government with the purpose of handling a vertical imbalance in fiscal capacity in the country (Presidential Decree, 2000).

The general allocation fund is based on the long term goals of the health programmes. The general allocation funds from Central Level consist of General Allocation Funds for Provinces and General Allocation Funds for Districts/Municipalities; the amounts are set as follows: for Provinces 10% and for Municipalities/Districts 90%. The allocation is made by considering the anticipated budget burden of each region on the basis of the amount allocated from Regional Routine Funds and the Regional Development Funds for the ongoing fiscal year (Presidential Decree, 2000).

The special allocation fund (DAK) originates from Central Level and is allocated to regions to help finance specific needs, particularly to finance programmes which constitute commitments or national priorities (MoF, 2000). Of particular interest to this thesis, the DAK provided support for the essential health programmes for IDPs through providing and maintaining health facilities and health equipment such as buildings, ambulance, motorbike and medical instruments.

'Other legal revenue' includes fees for services, insurance from government employees and from the Bureau of Family Planning for family planning services.

3.5 Manado Municipality Health Office Organisation

As an organisation the Manado MHO states that it has a vision and a mission. The vision of Manado MHO is to promote Manado Municipality as a centre noted for health services and community participation. The mission of the Manado MHO is to increase municipal development through positive health concepts; empower the community in attaining a healthy life style; maintain and increase the quality of health services, making these services equal and accessible to all; maintain and increase the health of individuals, families and the community.

To achieve this mission, the following strategies are relied on:

- increasing the quality of human resources
- improving environmental health
- improving the quality of health services;
- promoting healthy behaviour and empowerment of the community;
- maintaining and extending the health facilities so that they cover vulnerable people (Dinkes Manado, 2003).

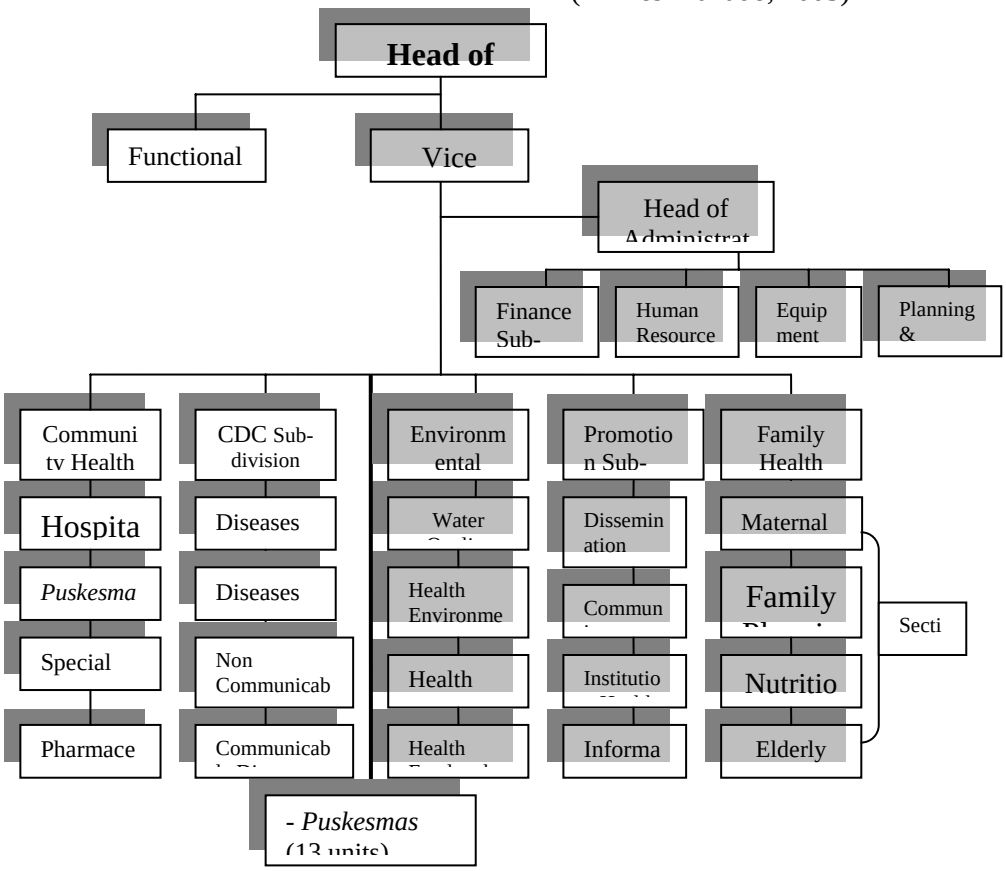
3.5.1 Structure and Organisation Functions

Organizational structure of a municipal/district health system is the framework that defines formal reporting relationships between different levels of management. It is the mechanism that operationalises the management of the organization (Lane Education Serve District, 2003). The organisational structure of Manado MHO refers to the levels

of management within the municipal health office. It defines the municipal health office's chain of command to every sub-division and section as well as the *puskesmas*. Under the organisational hierarchy of Manado MHO, there were 13 *puskesmas* distributed over 9 sub-districts that provided health services to all communities in Manado municipality. The Manado MHO is headed by a medical doctor. Under her there are several sub-divisions and sections (Figure 3.5).

Figure 3.5: Organisational Chart of Manado MHO

(Dinkes Manado, 2003)



The Manado MHO is involved in developing an integrated approach to the delivery of public health programmes and providing essential health services to the community in Manado Municipality. The office offers a comprehensive package of health promotion, prevention, and curative and rehabilitative services to the community.

The main functions of Manado MHO and Sampang DHO closely follow those outlined in section 3.4.1:

- To promote for the health of the Municipality within the municipality development policies
- To increase the capability of community and public sectors in encouraging a healthy life style
- To improve the quality of resources in the health sector through community participation and the private sector.
- To promote positive health initiatives and preventive measures in order to increase the number of healthy individuals and a healthy community (Dinkes Manado, 2003).

In addition, other functions of the M/DHO include coordinating top-down and bottom-up planning; organizing community involvement in planning and implementation; and coordination of public and private health care. The objectives are to expand access to priority health programmes to promote health development and to achieve health equity in the community (Dinkes Manado, 2003; Dinkes Sampang, 2003).

Most of the tasks of the MHO involve management of the health programmes and services. The MHO does not provide health services delivery directly to the community, which is the responsibility of the *puskesmas* and other sub-district facilities, but deals with the management of health programmes and services in the municipality. The MHO provides technical and administrative supervision, improving logistics for supplies, drugs and equipment to the *puskesmas*, and supporting the *puskesmas* in their responsibility for essential health services delivery, including integrating services with other sectors (Dinkes Manado, 2003).

The MHO supports and maintains all the health facilities and equipment and provides basic medicines, laboratory services and referral services within the district, the capital city and sub-districts. The MHO has a health information system to monitor and evaluate the health services activities (Dinkes Manado, 2003). The MHO is also responsible for environmental health, sanitation, including the provision of clean water and supports the community's health development projects.

3.5.2 Health Infrastructure

Manado municipality, being the capital city, has a referral hospital providing curative and rehabilitative services to the municipality and surrounding provinces. In the municipality there is no hospital belonging to the municipal government but there is one provincial public hospital as a referral hospital and one mental hospital. There is also two private hospitals, three military hospitals and five maternity clinics as well as other private practitioners. Other public health facilities include 13 *puskesmas*, 52 *pustu*; 1 *pusling*; 51 pharmacies. 53 drug stores are also available in the town (Dinkes Manado, 2003).

3.6 Sampang District Health Office Organisation

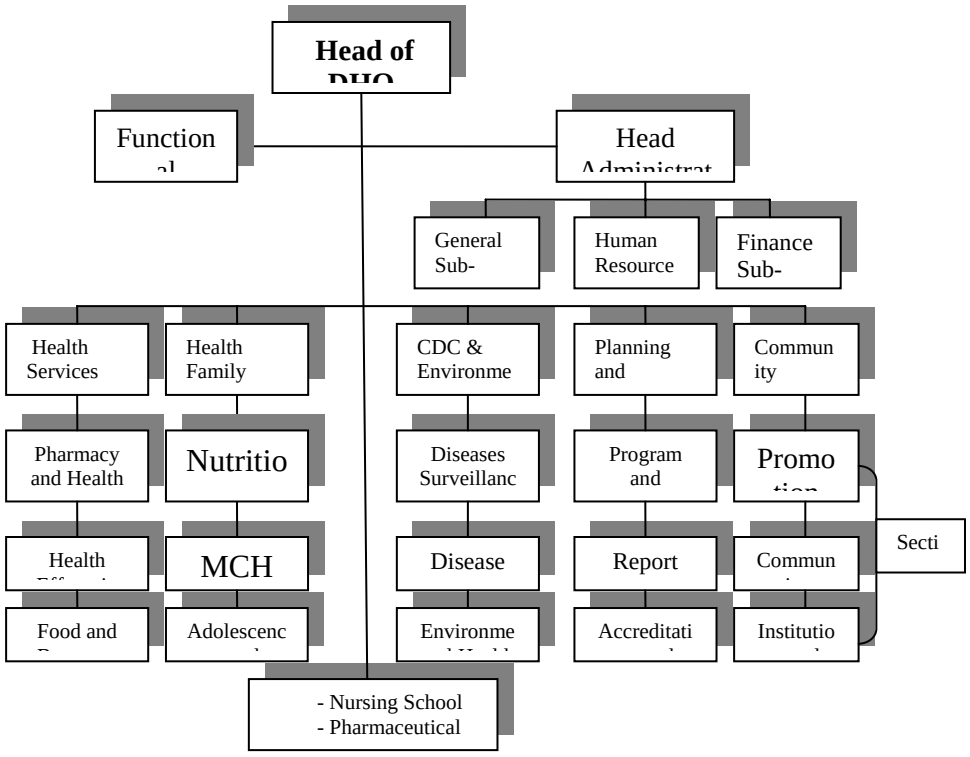
The DHO is a focal institution for health issues in Sampang district in terms of developing health programmes and providing health services to the population in the catchment area. The DHO is responsible to the Local Government. The health programmes formulated and developed by DHO have to be passed and approved by the district government.

The vision of district health development in Sampang district is of increased community health status through the creation of quality health services in support of health development. The mission is to increase the capability of communicable diseases control, surveillance and maintenance of a healthy environment; to improve the quality of health services; to improve family health and nutrition in the community; to improve health management and information and to encourage the community to maintain their health (Dinkes Sampang, 2003).

3.6.1 Structure and Organisation Functions

Figure 3.6 is the organizational structure of Sampang DHO. Under the organisational chain of command of Sampang DHO, there were 20 *puskesmas* distributed over 12 sub-districts providing health services to all communities in Sampang district. The Sampang DHO was headed by a medical doctor. Under him there were several sub-divisions and sections that were responsible for developing health programmes and translating the technical policies from central level.

Figure 3.6: Organizational Chart for Sampang DHO
(Dinkes Sampang, 2003)



The DHO of Sampang district offers a comprehensive package of health promotion, prevention, curative and rehabilitative services to the local people. The functions, as stated in "Organisation and Management" released by the Law Division of District Government (2002) are to deliver health care to all local communities by:

a. Planning and setting up standards and guidance for health programmes
b. Developing health programmes
c. Developing personal health services
d. Controlling communicable diseases and promoting a healthy environment
e. Providing health administration facilities
f. Granting permits for health services by private providers
g. Establishing of technical units in health development.

The DHO is responsible for environmental health, sanitation including the provision of clean water and supporting the community's health development projects in the district. It supports and maintains all health facilities and equipment including the provision of basic medicines, laboratory services and transport within the sub-districts and to the capital city of the district. The DHO also develops a budget for district health finance following the national and provincial guidelines. It is involved in implementing national health policies such as health decentralisation and management of care. This also includes the creation of a health information system to monitor and evaluate health service activities in the district.

The responsibilities of Sampang DHO are laid out in the technical health policy of the central MoH and delivered according to the local situation. The DHO is in charge of supervising service delivery of the *puskesmas* and pharmacies, and integrating health service with other local sectors (Dinkes Sampang, 2003).

Like Manado MHO, the Sampang DHO does not provide health services delivery directly to the community, but deals with the management of health programmes in the district.

3.6.2 Health infrastructure

Sampang District has one hospital and 20 *puskesmas* dispersed in 12 sub-districts. Several sub-districts have 2 *puskesmas* and every *puskesmas* is equipped with standard medical equipment. *Puskesmas* with 10 beds were equipped with the standard medical equipment of a mini hospital. The *puskesmas* are also supported by non-medical equipment including cold chain kits, furniture, motor cycles, *pusling* for out-reach services and referring patients to the public hospital (Dinkes Sampang, 2003). Compared to Manado, the private sector is considerably less developed but there is no data on their number (personal observation).

3.7 Decentralisation

The world has increasingly turned towards the practice of decentralisation to assure democratic governance for human development and improving services to communities. Decentralisation can be defined in general terms as the transfer of authority, or dispersal of power, in public planning, management and decision making from a national level to a sub-national level, or more generally from higher to lower levels of government (Mills *et al.*, 1990). The goal is to improve the latter's functions, duties, and responsibilities. Implicitly, the scheme mandates the local government with enhanced capacity to mobilise local resources that can be utilised at their own discretion for local development (IDRC, 1997; Hutton, 2002). Decentralisation usually refers to a political reform, designed to reduce the extent of central influence and promote local autonomy (World Bank, 2005b). Decentralisation is also action by a government to empower their respective local communities to develop their own local areas and resources.

Initially, decentralisation was seen primarily as a means of improving the coverage, quality and the efficiency of public education, infrastructure development projects and public health services. It was also seen as an opportunity to involve community organisations, stakeholders in the private sector, international aid organisations and citizens in the development of services. More recently, it has also come to be regarded as a method for increasing equality, government accountability and promoting community participation at the local level, or more generally, strengthening democratic participation

(Peterson, 1997; Bossert, 1998; Brinkerhoff, 2003). The move to decentralisation has a wide appeal and a feature of modern state administration is the need for closer contact between the individual citizen and officialdom (Smith, 1985).

Decentralisation has been acknowledged as an instrument capable of improving public services in both the developed and developing world and has increased potential to more effectively address poverty, gender inequality, environmental concerns and the improvement of healthcare, education and access to technology (Bathia and Mossialos, 2004). However, decentralisation may also bring about disadvantages to the system. Among these are: lack of control over the local institutions leading to inefficiency in managing the government's budget; widening the gap between and among regions whereby wealthy and progressive regions could develop their economy better faster while poorer regions are left behind; and intensifying regional sentiments at the expense of endangering national unity (IDRC, 1997). Poor districts will face difficulties in developing programmes and providing services to their population based on their resource capacity and this situation could create high dependency on the central level and retard the process of health decentralisation. This situation is related to Indonesia's situation where many districts are poor in natural resources and the capacity and number of human resources.

Decentralisation is often classified by the type of responsibilities devolved and by the level of autonomy granted to the local authorities. A common taxonomy classifies decentralisation by three categories of devolved responsibilities: political, administrative, and fiscal (Hutton, 2002; Hutchinson and LaFond, 2004).

Decentralisation often promoted and to centralised decision making with the aim of providing public services in a more effective and efficient way in terms of resource availability. Many countries in the world particularly in developing countries are pursuing decentralisation to counter in-efficiencies, and ineffective governance and services, including health systems.

3.8 Decentralisation Policy in Indonesia

In Indonesia decentralisation was an important policy under the Regional Development Law No. 22, 1999, passed by the Indonesian Parliament and President, which was an attempt to decentralize both political and economic power after decades of highly centralized and autocratic rule. The formulation of this was forced on the government as a result of pressures and dissatisfaction from the societies outside Java Island who felt they were exploited and treated unfairly (Suwondo, 2002). The law gives full autonomy to municipalities and districts to administer public services, but not in areas such as foreign policy, defence, security, justice, religion, financial and fiscal policy. The same law also makes local government responsible for all decentralised government ministries at provincial and municipal and district levels. However, at that time the local government was not elected by the local community.

The decentralisation policy represented by Law 22, 1999 has had an enormous impact on all aspects of government and governance. It was against this background that the government of the former president Habibie introduced “radical legislations” which allowed sweeping regional autonomy (Betts, 2003). The form of decentralisation in Indonesia is devolution, which refers to: attempts to devolve powers to democratically elected local governments, make local governments more accountable to communities through the establishment of oversight boards, and the introduction of new forms of community participation in development projects and policy-making including health.

Indonesia is still in the midst of the decentralisation process. Because the implementation of the 1999 laws was perceived by central government as creating the problem of conflicting authorities, the former president Megawati’s government initiated a revision to the 1999 autonomy laws. In 2004, Act Number 22 Year 1999 (Regional Government) became Act Number 32 Year 2004, which provided clearer and more detailed regulations for the implementation of decentralisation and regional autonomy.

Local authorities are being given political power to make decisions such as electing their own mayors/regents and legislatures, raising revenues, and making independent

investments. Administrative decentralisation seeks to redistribute authority, responsibility and financial resources for providing public services among different levels of government.

One of the major breakthroughs introduced by Law 32/2004 is the introduction of direct elections of the Heads of regions. Priyono stated that

> *"…the most significant change of the law was the change in government administration and the shift of central level politics to local level politics. Indonesia would hold direct election for Heads of region at provincial (governor) and municipal and district levels (mayor/regent)"* (Priyono, 2005: 1).

Since June 2005, Indonesia has implemented this new election system for the first time, with 11 governors, 178 regents and 35 mayors elected directly by the community. This can be seen as a great step forward to consolidate Indonesia's democratic system.

The decentralisation process in Indonesia, in terms of its scope and speed, is unprecedented. Designed to provide operational autonomy to district governments, bring decision making on public services closer to the people in a geographically vast country, and allow greater local discretion and opportunities for citizen participation, the reform agenda has had to balance the distribution of powers between the national, provincial, and local governments (ADB, 2004). While the law was enacted in a bid to nurture democracy in the country, many have warned of a possible backlash over its many confusing stipulations (The Jakarta Post, 2005). Decentralisation in this country was introduced in less than favorable economic, social and political conditions. For example, as noted in earlier chapters, the 1997 Asian financial crisis, complex emergencies, natural disasters and current conditions in the country hampered the progress of decentralisation. The areas which had a sufficient human workforce and resources found it easier to accomodate the decentralisation policy than the areas without. Furthermore, the readiness of local governments and communities were contributory factors in the introduction of health decentralisation.

3.9 Health Decentralisation Policy

Health policy can be seen as networks of interrelated decisions, which together form an approach or strategy in relation to practical issues concerning health care delivery to the community (Green and Thorogood, 1998). Since the beginning of the 1980s the decision makers in health authorities, including donor agencies, have faced challenges to reform at both the organisational and the operational aspects of the health system and in delivering new policies (WHO, 2000e). This has been especially necessary in view of the commitment to health decentralisation in developing countries.

Health decentralisation policy is one of the principal elements of health sector reform in a number of countries. It has increasingly been recognised, at both national and international levels, that management, financing and policy functions in the health sector may be carried out more efficiently and effectively if they are decentralised, transferring responsibility to local level.

The concept of health decentralisation has become a basis of policy making in many nations. In certain respects, decentralisation has become a synonym for a strengthened process of regionalization not just in the health sector, but in broader social as well as political arenas (Saltman and Bankauskaitev, 2004). Hutton added that “power can be handed down in terms of planning, financing, managing, and operating the health system” (Hutton, 2002: 3).

Health decentralisation, as a specific health policy, has become a common strategy for many developing countries. It is an attempt to improve primary health care for the population through the empowerment of the local health authorities and the participation of the community. In recent years, a number of countries (for example, Philippines, Indonesia, Kenya and Tanzania) have experimented with various forms of decentralisation initiatives, usually as part of a broader process of political, economic and technical reform with the aim of improving their health system (Bossert, 1998; Litvack *et al.*, 1998; Bathia and Mossialos, 2004). Health decentralisation in Indonesia is currently at the stage of devolving health authority from central to the local level, in order to improve health programmes and services and allow for community participation.

3.9.1 The Concept of Health Decentralisation Policy

Health decentralisation seeks to create a democratic environment and institutions for governance and development at the local level. It appears that a policy of health decentralisation is an important element in the potential success of primary health care policies, especially in terms of improving management of health services delivery and programmes offered by public and private health sectors to the community.

Rondinelli and colleagues (1981), Mills and colleagues (1990) and Omar (2002) have outlined the important institutional differences of four different forms of health decentralisation: deconcentration, devolution, delegation and privatization. *Deconcentration* refers to shifting power from central to peripheral Ministry of Health (MoH) offices. It implies establishing local management with clearly defined administrative duties and with a degree of discretion that would enable the local officials to manage without constant reference to the MoH.

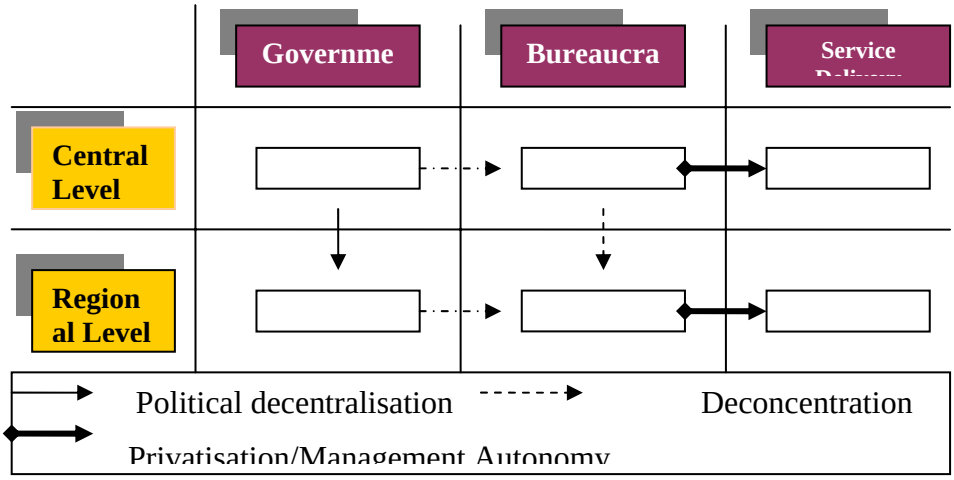
Devolution refers to shifting power from the MoH to local, state or regional authorities. They are rarely 'completely autonomous' but are bodies largely independent of the national government in their areas of responsibility e.g. raising revenue and staff appointment. The policy function is usually the only function retained centrally. Devolution is usually part of a national programme of political decentralisation.

Delegation shifts power from the MoH to semi autonomous agencies. Ultimate responsibility remains with the MoH, but its agent has broad discretion to carry out its specified functions and duties.

Privatization refers to contractual agreements established between the public and private sector for delivery of services This involves the transfer of government functions to voluntary organisations or to private profit-making or non-profit making enterprises (Rondinelli *et al.,* 1993; Omar, 2002). These concepts are now commonly used to differentiate between different forms of health decentralisation. This found of decentralisation taken by Indonesia is discussed in section 3.8.

GTZ and USAID proposed a general concept of decentralisation in service delivery (Figure 3.7).

Figure 3.7: Concept of Decentralisation in Service Delivery
(Adapted from GTZ and USAID, 2000)



This figure indicates there are three aspects in the transfer of responsibility away from central level; de-bureaucratisation (deconcentration), empowerment at local level (political decentralisation) and managerial decentralisation (privatisation/management autonomy). These are common features in a decentralisation policy (GTZ and Clean Urban Project USAID, 2000).

Bossert and Beauvais add the rider that:

> *"health decentralisation is a dynamic relationship of changing powers between the centre and the periphery; not a granting of full power to the periphery"* (Bossert and Beauvais, 2002: 14).

The concept of health decentralisation policy thus encompasses the transfer of responsibility for planning, management, resource generation and allocation away from the central government and its agencies to the periphery.

Decentralisation involves not only allocating health programmes and services responsibilities to provincial and municipal/district levels but also defining their relationships with each other and with the central level (MoH RI, 2003c).

3.9.2 Objectives of Health Decentralisation Policy

According to Fiedler and Suazo (2002) the objectives of decentralisation are diverse. On a philosophical and ideological level, decentralisation has been seen as an important political ideal, providing the means for community participation and local self-reliance and ensuring the accountability of government officials to the population. On a pragmatic level, decentralisation has been seen as a way of overcoming institutional, physical, and administrative constraints on health development.

It is believed that health decentralisation will put decisions in the hands of those who are most familiar with local problems and needs and have greatest access to essential information. This, it is felt, will increase the speed and efficiency with which decisions are made, as well as reducing bureaucratic red tape (Gross and Rosen, 1996).

It has been argued that health decentralisation improves governance and public service delivery by increasing allocative efficiency through better matching of public health services with local preferences and productive efficiency through increased accountability of local government to citizens, a lower level of bureaucracy and better knowledge of local costs (Boven, 1996; Kahkonen and Lanyi, 2001). In addition, improving equity has come to be championed as one of the major reasons for decentralisation, despite the fact that there have been few explanations as to how it is supposed to do so (Litvack *et.al.*, 1998). Collins (1989) argues that decentralisation potentially undermines equity, especially programme disparities.

In addition, according to theories of public administration, decentralisation should increase the responsiveness of services to local needs and facilitate mobilisation of bureaucracies. It is claimed that it can lead to improvements in equity, efficiency and effectiveness (Tang and Bloom, 2000).

Decentralisation has many potential advantages: it focuses attention on the community, may promote community participation, may encourage a more equitable health service provision, may improve the motivation of local staff, may speed up the implementation of development programmes and may promote inter-sectoral collaboration (Atkinson, 2002).

The very essence of decentralisation, Atkinson argues "is to increase the space for decision making at the local level for the local level so that the health system will be more responsive to local needs and thus more effective and efficient in the provision of health care" (Atkinson, 2002: 113). Perhaps the most important potential advantage of decentralisation for health service delivery is allowing a closer flow of information and interaction between health service providers and consumers, leading to health services more effectively meeting local needs (World Bank, 2001). Kahkonen and Lanyi (2002) also found that decentralising service delivery has potential benefits but these benefits have not always materialised e.g. local officials perceive local demands but have limited authority to adjust services and also corruption can be more pronounced at local than at national levels.

In the countries that have implemented decentralisation there are many different examples of ways to manage the decentralisation process. Not all have progressed through the process without challenges. According to Mills and colleague (1990) the situation can be made more complex when countries adopt a policy for the decentralisation of certain functions while at the same time centralising control over others. For example, it is not uncommon to decentralise the recruitment of health personnel and some administrative procedures while retaining central control over finance and budgets. This may make the service more inequitable, may make it more difficult to promote national policies, priorities and standards, may intensify existing shortages of trained managers and may be less efficient.

One of the dangers sometimes flagged up with decentralisation is the possibility that inequalities between different local systems might become greater without centralised management (Atkinson, 2002). Indeed Collins argues

> *"decentralisation in itself does not guarantee that service delivery will be more responsive to the local needs; elite groups are just as likely to pursue their own interests as central level officials and politicians"* (Collins, 1989: 168).

Many people believe that decentralisation will provide opportunities for corruption in the health organisational structure, projects and services as Prud'homme noted

> *"decentralisation can lead to increased corruption and the entrenchment of local political elites, when political power and financial resources are transferred into structures without democratic accountability. Corruption is more widespread at the local that at the national level, then decentralisation automatically increases the overall level of corruption"* (Prud'homme, 1995: 211).

Increased powers of local governments can conflict with the activities of neighbourhood groups in urban areas, or with traditional common-property regimes in rural areas. Local government especially in poorer rural areas often lacks the resource base (both human, in terms of appropriate skill, and financial) to provide high quality services. Horizontal co-ordination can be a problem where local government maintains vertical distinction between different service sectors (Walker, 2002).

In some cases, the limitations of decentralisation have resulted in a backlash against the reforms and initiatives for recentralisation (Bossert and Beauvais, 2002). In order to minimise its negative effects and maximise positive outcomes, health decentralisation must be operationalised and coordinated with related sectors. A comprehensive approach to the implementation of decentralisation and a strong commitment among implementers in the municipality/district level are needed if success is to be gained.

3.9.3 Factors Influencing Health Decentralisation Policy Implementation

Health decentralisation policy is initiated by central governments. Before decentralisation can be implemented, the central government or MoH needs either to initiate a national policy by issuing a decree and document it as part of a programme of national development or adopt constitutional changes and seek approval from the legislative assembly and set the pattern for the reforms to be adopted by different ministries (Vaughan, 1990). In the process of planning, it is important to consider the changes in roles, responsibilities and functions at every level from central to Provincial Health Office (PHO) and Municipality/District Health Office (M/DHO) because the actions for implementing the health decentralisation rely on these intermediary and

lower institutions. In addition, the role of a local parliament in political decision making regarding the approval of a local health budget influences the health programmes and services for the local community and vulnerable people.

In local government where a local health authority is attached, more responsibility and financial resources come along with greater political autonomy. Following decentralisation, in which regulatory roles have been passed on to the regions, an issue emerges as to whether the regions are capable of taking on this role. If the role is to be discharged effectively then there must be human resources in the region competent in their field (CHSM, 2004*).* The readiness of local governments to accept responsibility for running the health programmes and projects is important factor of devolving the health authority.

In countries with geographical differences in capacity and resources, especially human and natural resources, the problems posed in implementing health programmes will also be different. Provinces or municipalities/districts with abundant resources are likely to find it easy to accept the concept of decentralisation. However, provinces or districts with scarce resources may face difficulties in implementing health management programmes or projects (Bossert and Beauvais, 2002). This is relevant to situations in Indonesia, for example in Manado and Sampang. Manado is a town of around 400,000, whereas Sampang is a poor rural area with a scattered population.

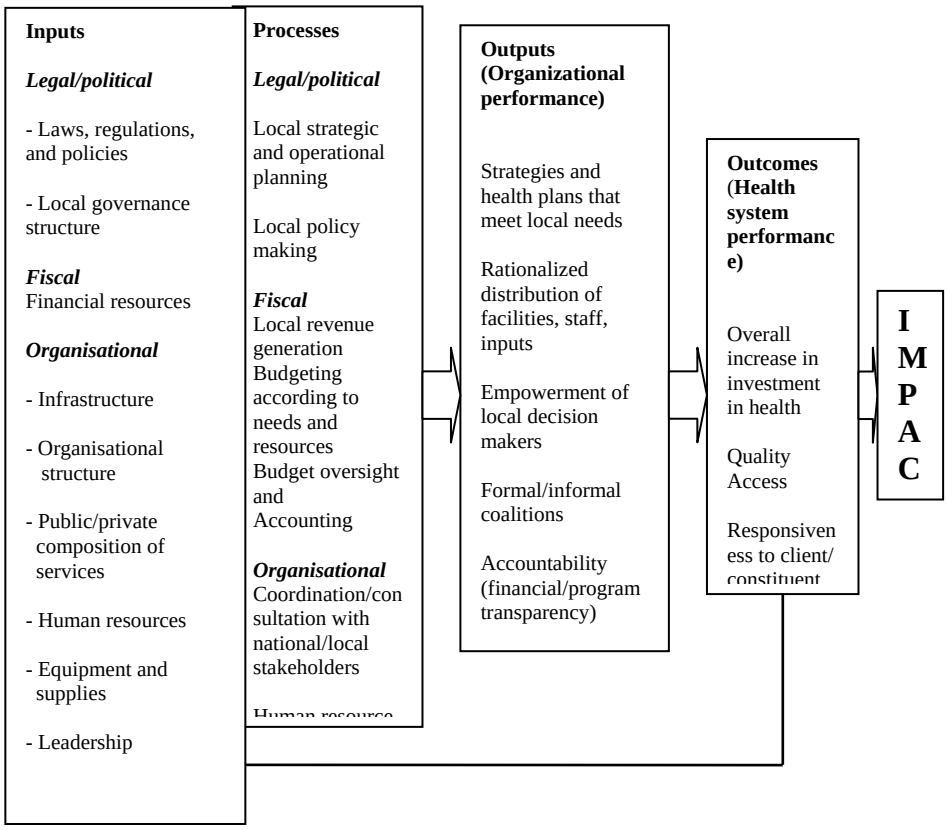
Several problems may ensue from health decentralisation. Firstly, lack of co-ordination in health institution may hamper deliver of programmes and services. Secondly, competence by health workforce may deteriorate due to geographical isolation. Thirdly, while too much top control may reduce initiative and creativity, a decentralised organisation's ability to release creativity may have limits. Fourthly, the spread of power among several Heads may lead to conflict resulting from an unclear division of authority or simply the pursuit of personal ambition (Aas, 1997).

Decentralisation is thus a lengthy and complicated process requiring continuous development and adaptation if it is finally to improve the actual coverage, efficiency and effectiveness of primary health care; the final consequences are not always clear at the beginning. It has often taken up to ten years or more before a decentralised system works well. Thus a long-term political commitment is required to make decentralisation a success (Mills et al., 1990). Political willingness of central level to introduce political reform at every level of government in order to devolve power is very important in the implementation of health decentralisation.

3.9.4 Monitoring and Evaluation of Health Decentralisation Policy

Hutchinson and LaFond (2004) developed a conceptual framework (Figure 3.8) for the monitoring and evaluating of decentralisation at local level. The framework follows a standard progression in monitoring and evaluation. It begins with health system inputs, outlines key processes essential to the proper functioning of a health system and identifies common outputs and intermediate system goals of decentralisation and outcomes in such a system.

Figure 3.8: Evaluation at District Level
(Hutchinson and LaFond, 2004)



In this framework, the key **inputs** in a decentralized health sector are considered to be of several types, largely categorized into legal/political, fiscal, and organisational variables. The key political inputs include the laws governing the health system and the functioning of the public sector, including electoral policies, the regulations and standards that dictate satisfactory performance of the system and the policies that determine the system's goals and the mechanisms for achieving those goals. Laws, policies, norms, standards, regulations, and historical tendencies also shape the financing and organisational structure of the health system.

On the organisational side, actors, particularly at the local level, decide the level and distribution of health facilities and programmes and their corresponding staffing and supply characteristics (infrastructure, drugs, supplies and equipment and operations and maintenance). These inputs also include the organisational structure of the system, the roles of public/private providers, the treatment of human resources (procedures for hiring, firing, sanctioning, and rewarding), procedures for infrastructure investment and upgrading and aspects of health sector leadership and stewardship undertaken by government health officials.

Processes and process indicators, which are described in subsequent sections, are intermediate factors referring to activities that improve the quality, accessibility, distribution, and efficiency of service delivery and health system functioning. The key processes monitored in a decentralisation programme are those that demonstrate the redefined roles and responsibilities of key actors, changing the authoritative structures of the health system and the means and focus of accountability and highlighting the new capacities needed to fulfil different functions.

Outputs of decentralisation are the intermediate improvements in the organisational performance of the health system. These might reflect the improvements in policies and programmes to better reflect local needs and conditions. They might also reflect a system that better responds or is more accountable to stakeholders through local elections, market mechanisms, or community input or a system that performs in a more ideal manner because regulations are enforced and standards adhered to. These outputs might also include better use of information to inform and improve upon service delivery and policy making; more equitable distributions of health resources and services; or higher quality services and greater adherence to standards.

Outcomes of decentralisation are likely to reflect many of decentralisation's stated goals – efficiency in service delivery, improved quality, more equitable access to and use of health services and services that reflect constituents' wants and needs.

The **impact** of decentralisation relates to the long-term effects on incidence of disease, survival, quality of life, and sustainability (Rehle and Hassig, 2001). While input, process and outcome variables are normally included in a standard monitoring and evaluation plan for decentralisation, studies to evaluate the impact of decentralisation on health status are not *routinely* undertaken for national or local routine monitoring and evaluation (Hutchinson and LaFond, 2004).

At the time of this research the process of decentralisation was still going on in the two field areas. Several elements of evaluation were considered as tools included the input and process of the health decentralisation policy, particularly its general effect on the health systems at the municipal and district level.

3.10 Health Decentralisation Policy in Indonesia

The decentralisation policy has had an enormous impact on all aspects of government and governance in Indonesia (Betts, 2003). The devolution of power to the regions, involves not only the regional government as an executive branch, but also the local parliament as a legislative branch. The checks and balances of power, which previously operated at Central Level, were now divided between the municipal/district executive and legislative power in the local region (GTZ and USAID, 2000).

When decentralisation was proposed by the Indonesian government policy, the reaction from the Indonesian Ministry of Health was prompt and positive. The implementation of Act Number 22 Year 1999 (Regional Government) and Act Number 25 Year 1999 (Financial Balance between Central and Region levels) strongly influenced the rate of development including health development.

The key elements of the Acts above went into effect along with many accompanying operational guidelines on 1 January 2001. During 2000 the MoH began to clarify its own role and tasks in a decentralized administration, as well as those of provinces and districts. High priority was given to developing a sectoral vision and translating it into a policy agenda (Lieberman, 2001). To carry out these responsibilities, the MoH looked

at various initiatives including: a Decentralisation Unit (DU) set up within the MoH to carry out problem solving, coordination and analytical functions. The aim was to facilitate health decentralisation and reform, monitor implementation by local areas and advise on existing and proposed legislation and operational guidelines. Resource transfer mechanisms, e.g., National Health Grants, helped to support health operations in poor regions. Directorates General (DGs) within the MoH were converted into specialized agencies, tasked with disseminating recommended standards and practices and assisting provinces and districts in upgrading and sustaining important technical functions (Lieberman, 2001; Azwar, 2004).

Decentralisation of health responsibilities offers authority to the municipalities and districts to determine their own priorities in health development with respect to local capabilities, conditions and needs. As a consequence, success in health development in the future will depend very much on the capability of the health workforce resources in the regions.

Health decentralisation policy results in major changes in the organisational structure at central, provincial and local levels. With the Acts local level of health authorities have greater opportunity to decide on their own priorities in health development according to their respective needs, conditions and available resources. On the other hand, there is widespread concern regarding whether or not local governments are ready and capable of discharging the tasks consequent on health decentralisation.

The decentralisation policy created new relationships between different levels of government and between these levels and the health system. In light of the concerns of the thesis, it is important to understand how these horizontal and vertical relationships between health programmes and the relationship with the community and other organisations affected the policy related to developing health programmes and providing service to the population. Vertical and horizontal relationships of M/DHO are important in terms of coordinating and providing better health services to the population.

Coordination and integration of health programmes and services particularly in health are needed in order to achieve the goals of health system (WHO, 2001c). This research reviewed the relationships between the M/DHOs in the study sites with other organisations such as Local Government and Parliaments, the MoH, the PHO, local hospitals and NGOs and the private sector that influenced programmes and policies in the contex of decentralisation.

3.10.1 The Relationship between the M/DHO and the Local Parliament

Since their commitment to decentralisation local government, the health programmes and services delivered by the M/DHO are influenced by the municipal/district parliament, where the health programmes have to be approved by the local parliament. The function of the local parliament includes approving the budget for health development in the district and municipality (Dirjen Otonomi Daerah, 2004). As a result, in order to implement planned strategic health programmes developed by the M/DHO they have to be presented to the local parliament. In addition, the budget request for support of the health programmes, particularly that raised from local sources, must be approved by the local parliament.

This liaison between M/DHO and the local parliament was a new relationship for municipalities and districts in Indonesia created by the 2001 decentralisation policy. It was believed that it might improve the management of health programmes and services for the local community and the vulnerable people by increasing the responsibility and accountability of the M/DHO to the community through the local parliament.

3.10.2 The Relationship between the M/DHO and the Local Government

A key function of local government regarding health is policy coordination between sectors. Some major determinants of health are outside the health system, that is, in sectors such as education, public works, transport, economic and social policies (Leppo, 2001). The role of the Local Government is important in order to coordinate and achieve the goals of the health systems within the sectors in the municipality/district.

The programmes and services implemented in the municipality/district were part of the local government's working agenda. The M/DHO is under the direct control of the Head of the Municipality/District in its function of developing and conducting health programmes and services. When a new health policy is to be applied to the community it has to be approved by the local government and the Mayor and the Head of the Municipality/District must apply for political and budgetary support**.**

Approval of the budget for supporting the health activities and maintaining the health infrastructures and facilities is required from the municipal/district executive following the local parliament approval. In addition, part of the local health budget for health development in the municipality/district comes from local government sources.

3.10.3 The Relationship between the M/DHO and the Ministry of Health

The MoH is the architect and the overseer of health regulations and the planning of national health programmes. The responsibility of central government for developing national health planning and policy includes: general co-ordination of health activities and basic health legislation; financing health systems and regulating the financial aspects of managed care; pharmaceutical policy; skill and knowledge development of the health workforce (MoH, 2003a). The MoH also controls overall health policy. Other responsibilities are to build consensus on national health objectives and standards and to ensure local government and civil society groups meet their goals. The policies determined by the MoH are translated into municipal and district policies to meet specific municipal and district requirements across the nation.

3.10.4 The Relationship between the M/DHO and Provincial Health Office (PHO)

The PHO was responsible to the provincial government. Previously the PHO had only coordinated programmes, services and collected data in municipalities/districts for the provincial health profile, but because of the decentralisation policy the power of the PHO to control the M/DHO had been extended by the devolution of functions from the central level. The regional health office which had been the extended office from central level had been disbanded and the PHO was put in charge of health in the province.

Nowadays, the functions and responsibilities of the M/DHO are directly controlled by the PHO. For example, health policies and programmes formulated by the MoH are coordinated by the PHO. Also, the PHO is allocated a certain amount of money in order to support the health programmes in the municipalities and districts. In practical terms, health policies and programmes formulated at central level for implementation at district and municipality level were coordinated by the PHO. In this situation, however, the role of the PHO for the provision of health care for IDPs was limited to technical assistance. In this the PHO is working in line with the MoH's guidance.

Contact between M/DHO and PHO takes place every six months when the PHO conducts a health meeting in the capital city of the province. The agenda is based on the monthly visits to the M/DHO for evaluation of the programmes and services and the resulting monthly report. The meeting is attended by the Head of the PHO, the health programme holders from PHO, representatives from MoH, and the Heads of M/DHO. At this meeting, achievement of the targets of the health programmes are part of the agenda also the future health plans for the municipal/district population and health services.

3.10.5 The relationship between the M/DHO and the Local Hospital

The function of the relationship between the M/DHO and the hospital is to coordinate health service delivery. The function of the local hospital is to provide health services delivery, medical and non-medical health support, nursing care, emergency health care and intensive care for the population. In addition it provides education, training, and finance to the staff (MoH, 2001a). Moreover, it accepts patients who are referred from the *puskesmas* and may refer them on to the provincial hospital. The local hospital offers in-patient and out-patient care in general medical services and dental services. Services such as internal medicine, obstetrics and gynaecology, paediatrics and surgery are available.

Although the M/DHO determines and channels the expertise of the health workforces within their structural level, as well as medical service standards, drugs supplies and equipment, the hospital is not part of the organisational structure of the M/DHO. The

work of the M/DHO and the district hospital is coordinated by the local government, but the organisational function of both the M/DHO and the hospital were under the MoH and the PHO. In terms of health programme coordination, particularly in health services to the population, the hospital and the M/DHO work together with the local government and PHO.

3.10.6 The Relationship between the M/DHO and Non-Governmental Organisations, the Private Sectors and Other Institutions Related to Health

Health problems are national problems that cannot be disconnected from the various policies of other sectors; hence their solution should involve the other sectors (MoH RI, 1999b). For example, complex emergencies attract action to help the affected population, often from Non-Governmental Organisation (NGOs). These can be local or international and they play a crucial role in delivering a variety of services in complex emergencies. They vary greatly in terms of financial, technical and operational capacities (Muriuki, 2002). In managing and delivering the health service, the relationship between the M/DHO and NGOs is based on a partnership, where the M/DHO is the regulator in administering health programmes and services.

NGOs have been defined by The World Bank as "private organizations that pursue activities to relieve suffering, promote the interests of the poor, protect the environment, provide basic social services, or undertake community development" (Duke University, 2004: 1). NGO activities can be local, national or international. They have contributed to the development of communities around the world and are important partners of many governments – while remaining independent from governments (Delisle *et al.*, 2005). The role and contribution of international and local NGOs in health for IDPs is substantial and the contribution has been increasing over time, particularly in Indonesia in areas which have suffered from conflicts and natural disasters.

In the local communities and target populations where NGOs work they can act as community partners, members of, and witnesses to, health programmes and services. In this role they can assist with, for example, integrating their health programmes and services with those of the local health authority and other related health sectors (Widmer, 2001). But, the role of NGOs in the health field is not always readily accepted by all players. The challenge is to better integrate the NGOs into the municipality/district health system by intensifying partnership with government and private services.

In Indonesia private practitioners, which include paramedics, midwives, and doctors, are an important source of health care (Berman *et al.,* 1989; Linnan, 1990). The distribution of private practitioners partly reflects the facility allocation policies of the MoH through the M/DHO. Staff of public health facilities almost always operate private clinics and practices after public facilities have closed for the day (Berman *et al.,* 1987). Generally private services are much more available in urban that in rural area. This suggests that private practitioners prefer more developed areas where there are more residents who demand private services and can pay for them (Brotowasisto *et al.,* 1988). Private practitioners including traditional practitioners that exist in the district and municipality also contributed to the local health systems because they directly provide health services to the community. However, the focus of this thesis is the public provision of health services to IDPs and does not discuss the utilisation by this population group of the private sector.

3.10.7 The Challenges of Health Decentralisation Policy

Many problems and constraints have been reported since the policy launch in 2001. Among these reports is the Annual Forum on Health Decentralisation in 2005, organised by Gadjah Mada University, Hasannudin University, the Decentralisation Unit at MoH and WHO. According to the summary of the meeting, the organisation of a number of health programmes had produced a re-centralisation phenomenon (GMU *et al.,* 2005).

In 2005, the centralisation and decentralisation issue induced friction in the relationship between central and local governments. The Judicial review of the Constitutional Court

on the Social Security Acts was an example of centralised and decentralised conflict. In the context of the relationships among the central, provincial, municipal/district governments, the provision of Law No. 32 Year 2004 is considered a re-centralisation policy by some parties. The law asserts governmental authority over any action carried out by the central level, the provincial level and the municipality/district. Although, there was a policy and strategy for health decentralisation, and steps had been provided by the MoH, so far there had been an impression that the MoH had not emphasised health sector decentralisation in Indonesia (GMU *et al.*, 2005).

A radical change had been the mergers of the Regional Provincial Health Office (which belonged to the central level) with the PHO (that belonged to the provincial government) and the Regional District Health Office (that belonged to central level) with the DHO (that belonged to the district government). However, there was no significant change in the organisational structure of the MoH to acknowledge or take account of this. In fact the structural organisation of MoH does not reflect a decentralisation supportive organisation (GMU, *et al.*, 2005).

Moreover, in the MoH there was a serious problem regarding its capacity and that of the PHO and the M/DHO to develop the Ministerial Decree and Local Regulations for decentralisation. This situation was exacerbated when it was perceived that the commitment of the central government to develop decentralisation was low.

Nor was there a clear transfer of authority in some designated areas e.g.: licensing, financing health programmes for the poor. There was no systematic guidance, training and authority transfer nurturing process. There was a suspicious attitude and little communication between central level, provincial level, and municipalities/districts. Competition between central and local government had occurred in programmes such as hospital licensing and health insurance for the poor (GMU, *et al.*, 2005).

In the years since decentralisation was launched some progress has been reported regarding restructuring and reorienting the main procedural processes of the Directorate

Generals (DGs) within MoH. For example, the DG for Communicable Diseases Control has focused increasingly on monitoring national and regional trends, alerting provinces and the public to outbreaks. Generally however, the technical DGs have focused on adjustments within MoH, and have yet to adequately engage the district and province level-teams, which should be the audience for their technical inputs (Lieberman *et al.*, 2004).

On the other hand, slow development of a health decentralisation framework is attributable in part to the government-wide determination to avoid service interruptions. In addressing service problems, however, MoH has tended to present itself as a policing and standards-upholding authority rather than a technical support strategy (Lieberman *et al.,* 2004). The challenge to the local health authority includes: a) strengthening the capacity of the health workforce to relate to the local government and community; b) increasing the responsiveness of the health authority to their community through democratic institutions (legislative); c) enhancing the efficiency and quality of health services and infrastructure management; d) providing financial support for health development (Lieberman 2001, Azwar, 2004).

In addition, one concept of the role of the province in the health system was as facilitator between central level and district/municipality and to monitor health development in the municipality/district. It can be said that a clear concept of the role of the PHO in Indonesia is not clear enough.

3.11 Health Systems and Health Decentralisation Policy in Areas Receiving IDPs

The balance between efficacy and legitimacy, and between central authority and local autonomy, is delicate. A political system, which explicitly includes all citizens and groups, is often suggested to be pivotal for conflict prevention. There are basically two methods for sharing power between groups: decentralisation and inclusion in central government (Jarstad, 2001). Political factors, particularly in recipient IDPs areas, affect decisions regarding decentralisation. If political parties are weak and the society is divided, political parties may try to ‘play the ethnic card’ by proposing decentralisation to mobilize votes. At the same time - and especially after violent inter-group conflict - it

is important to find mechanisms to guarantee that no group can be ignored in political decision-making (Jarstad, 2005). Nevertheless, decentralisation can function as a mechanism for conflict prevention by removing conflict issues from the national political arena, thus reducing the number of issues to be agreed on jointly (Jarstad 2001). However, Mansfield and Snyder warn that

> *"under the imperfect conditions of a post-conflict situation, the mechanism of decentralisation that produces a democratic peace in mature democracies has the opposite effect in developing ones and can trigger nationalist war. Decentralisation can provide structures, which can be used as a basis for secession*" (Mansfield and Snyder, 2002: 298).

While decentralisation has been extensively studied, there is a shortage of studies that have investigated health decentralisation in the post-conflict environment, particularly in areas that either suffer the full impact of a conflict or are hosting refugees or IDPs. As mentioned in Chapter Two, health systems in the recipient areas may be faced with a huge number of IDPs arriving over a short period of time. Health resources in the recipient area, particularly in the poor areas, will be severely stretched and this may have an impact on the whole of the health system. Addressing the immediate health needs of IDPs is the first step in adjusting the health system. This must also consider the immediate needs of the receiving areas supported by the local health authorities. This involves anticipating and sustaining the health programmes, policy and services to the IDPs by adjusting the local health system so that it can accommodate the needs of the IDPs who stay temporarily or want to integrate with the host community.

Waters and colleagues (2006) make it clear that although post-conflict baseline data are frequently unavailable, particularly in the host area, there is unmistakable deterioration in the health conditions of a population following conflict. Excess mortality and morbidity, displaced populations and vulnerability to communicable diseases during and following complex emergencies all call for immediate relief and restoration of basic services. They also added that every complex emergency situation is unique and appropriate inputs and policies for reconstructing health systems vary accordingly including adjusting health systems in the recipient areas.

The process of adjustment of the health system in recipient areas may be seen as having three phases: (1) an initial response to immediate health needs; (2) establishment of a package of essential health services; (3) ensuring sustainability of the services (Waters *et al.*, 2004). However, this process has to consider the capacity of health authorities.

The policy of health decentralisation in Indonesia had to serve several objectives. The most widely pursued objective was the down-sizing of central government and removing the central level offices in the provinces and districts. It was not clear which health programmes and services were to be focused on the local community and which were specifically for the IDPs. This is related to the lack of clarity regarding health decentralisation policy, particularly that specifically for the IDPs.

Moreover, little research had been conducted to ascertain whether health decentralisation policy had indeed increased the coverage and quality of service delivery or if it had decreased, particularly in handling the health issues of IDPs.

Conclusion

This chapter has reviewed and assessed the concepts of health needs, reviewed the determinants of health and the setting of priorities. The particular definitions of health need will be used as a foundation for defining the health needs of the population involved in this study.

Health systems of some sort have existed for as long as people have tried to protect their health and treat diseases (WHO, 2000c). Within the elements of health systems there are many potential ways of achieving the goal of providing better health services for all and protecting vulnerable people.

This chapter has also demonstrated the link between health systems and health decentralisation policy, discussed in relation to providing a health service with potential benefits for the population concerned. However, sceptical opinions that decentralisation does not guarantee service delivery will necessarily be more responsive to local needs, were noted.

Achieving the objectives of health decentralisation policy in Indonesia needs strong commitment and co-operation between the internal and external sectors involved. A strong commitment among implementers in the central, provincial and municipal/district levels are needed if success is to be gained.

The following chapter will explain the methodology applied in this research.

Chapter Four

Research Methodology

Introduction

This chapter illustrates the methodology used in this research and considers the importance of the relationship between the researcher and the research process. It focuses on the methods applied in this research. It begins with the epistemology of the research and theoretical values that influenced the selected method; the conceptual framework; the method used following the process of research design, the development of the questionnaires, the sampling procedure, the collection and the process of analysing the data.

4.1 Epistemology

Epistemology is analysis into the grounds and nature of knowledge itself. Epistemology is the philosophy of knowledge. Epistemology deals with questions such as how do we know that our beliefs are true, what is truth, and how can we know it, and can knowledge be certain? (Schuyler, 2002; Swepson, 1995). Basically the above questions are translated into the issues of scientific methodology in order to allow the researcher to develop theories or models.

Epistemology is heavily influenced by ontology (Crotty, 1998). According to Gruber (1993) “ontology is an explicit specification of a conceptualization”. Epistemology is important because it is fundamental to the way in which the researcher thinks. The epistemology of this research was influenced by constructivism and post-positivism.

Constructivism is an approach that suggests the following: respondents present essentially thoughts and ideas; the core elements upon which they focus are inter-subjective beliefs (ideas, conceptions, assumptions, etc.) that are widely shared among them; the respondents’ shared beliefs compose and express their interests and identities: e.g. the way respondents envisage themselves in their situation.

Constructivism centres on the active participation of the subject in construing reality, rather than on reflecting or representing reality. It focuses on human awareness or consciousness and its place in world affairs (Jackson and Sorensen, 2005). In this research the reality which it was aimed to contruct was that of those who contributed issues of health, access to and utilisation of health services and their own health needs, rather than that of the researcher. Constructivism underlies the approach to data collection such as interviews, focus group discussions and semi-structured interviews.

The methodological approach of constructivism emphasizes inter-subjectivity or the experience of belonging to a common and shared social reality as a key element of post-positivism (Jackson and Sorensen, 2005). The reality of post-positivism is multiple, subjective, and mentally constructed by individuals (Crossan, 2003). Post-positivism adopts quantitative with some qualitative techniques to investigate phenomena (Corbetta, 2003). In this research post-positivism underpins some subjects and inter-subjects because the researcher was seeking to explore the differing perpectives of IDPs regarding their health and health providers in order for him to construct research activities, achieve the objectives of the research and answer the research questions.

As the researcher and the researched can have very different cultural and social backgrounds these can affect the research process, determining the way the research questions are conceptualized, which methods of data collection are pursued, the questions asked and the answers given. The researcher had previous experience of these differences when working in the setting of *puskesmas*, a provincial health office and at central level; also that research is a two way process, involving an interaction of ideas and perceptions held by both parties. For example, in the research process the understanding of ‘healthy life’ is related to differing norms of the researcher and the researched. This could affect analysis during the research process because of these dissimilar interpretations. Questions, methods and analysis were selected in order to overcome this problem.

In order to carry out the research in an effective manner, the researcher considered the significant characteristics of qualitative and quantitative methods i.e. mixed methods. In addition, the findings from one type of study were checked against the findings derived from the other type. The information gathered from respondents, particularly in surveys, was translated into numbers or quantified into a set of statements.

4.2 Theoretical Frameworks

The epistemological and ontological beliefs of the researcher and goals of the study are important. According to Bains (1997) they largely determine theoretical and methodological choices. Bowling stated that "scientists cannot divorce themselves from cultural, social and political contexts in their work. What scientists can do is make their assumptions about their world explicit and strive to conduct their research as rigorously and objectively as possible" (Bowling, 2002: 120). Theoretical frameworks for this research were influenced by the researcher's interests and working experiences in the public health setting in Indonesia, the current impact of Indonesia's ethno-religious conflicts and the decentralisation policy specifically as regarding health.

Whilst many theoretical perspectives informed this research, empirical analytic inquiry, interpretive inquiry and critical inquiry were the main influences. Packer explains that "empirical-analytic inquiry seeks objective metric or categorical descriptions of phenomena, and aims to provide causal explanations of their interrelationship in the form of formal laws tested through statistical measures of association among variables" (Packer, 1999). This research used statistical measures - procedures that produce descriptive statistics for analysed variables, including means, totals, percentages for sample surveys and other clustered data applications.

Interpretive inquiry "aims to characterize how people experience the world, the ways they interact together, and the settings in which these interactions take place" (Packer, 1999). This paradigm interpretive inquiry employs qualitative techniques such as direct observation, focus group discussion and semi-structure interviews.

Packer agues, that, although these two froms of inquiry are very different, they can be interpreted through critical inquiry. Critical inquiry he suggests "entails critique of the roles of force and power in social phenomena and in doing so provides a space for both causal and interpretive explanation" (Packer, 1999). Kanpol (1997) pointed out that "…critical inquiry involves interdisciplinary perspectives or methodologies to conceptualise, investigate and derive meaning" (Kanpol, 1997: 1). Crotty (1998) argues that those adopting a critical inquiry approach often have goals of equity and social justice and believe their research to be worthwhile. This researcher believes that vulnerable people require assistance to achieve fair delivery of health services and used his experience of working in the public health sector during periods of complex emergencies and decentralisation in this research.

Alvesson and Skoldberg (2000) stress that critical inquiry adopts a degree of scepticism regarding the idea that accepted ways of thinking are natural, rational and neutral. The critical inquiry approach to accepted ways of thinking is useful when researching policy (ibid). The critical inquiry approach promotes discussion about health policy, particularly health decentralisation policy that was one point of focus in this research.

4.3 Conceptual Framework of Research

A conceptual framework of research is a statement that captures the fundamental nature of the purpose of the research. It is the process of articulating the concepts, principles and values that form the objectives of the research and is more than a statement. It will be the guiding force behind the actions of the researcher (Blancquaert *et al*., 2003). A conceptual framework can help to explain the reasons for undertaking a research in a particular way. As the Psychosocial Working Group (2003) have described in their work on developing a framework for psychosocial interventions in post conflict situations: "a common framework is required with respect to which alternative formulations, strategies and, ultimately, outcomes can be compared and contested".

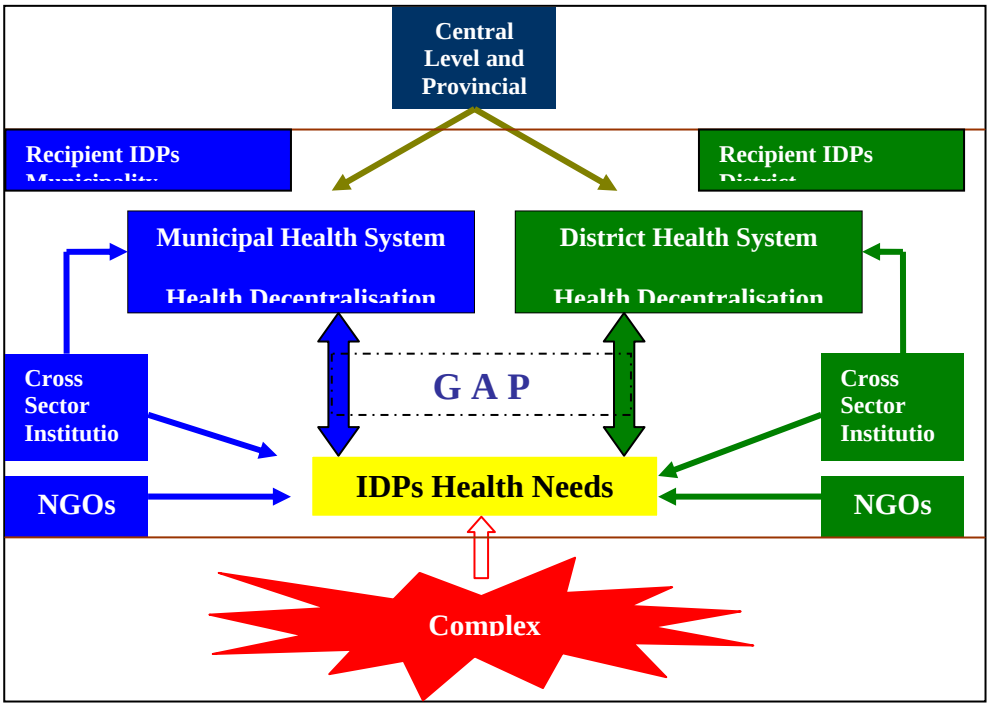
The purpose of this conceptual framework is to describe in an organized way the researcher's conceptual thinking in order to answer the core questions and achieve the objectives of the research.

4.3.1 The Structure of the Conceptual Framework

The conceptual framework for this research was influenced by the research objectives and questions, which were determined by the complex emergency situations and health decentralisation policy in Indonesia, particularly in areas that received IDPs. Complex emergencies created a large number of IDPs who had a major impact on the health systems in the recipient areas.

The conceptual framework of this research embraces both the opinions and experiences of third parties and the experiences and knowledge of the researcher. It includes also the aims and objectives of the investigation as illustrated in Figure 4.

Figure 4.1: The Conceptual Framework



The conceptual framework focused on the responses to the health needs of IDPs and the health systems of the recipient areas in developing health programmes and providing health services for the needs of the affected persons, also the IDPs experiences with health programmes and services under the existing system provided by the public sector. The effect of the health decentralisation policy on the local health systems particularly in developing health programmes and providing health services to IDPs was included.

The conceptual framework begins with the assumption that, in the context of the impact of complex emergencies on a community, in this case ethnic and religious conflicts that created massive destruction and displacement, the health needs of those displaced are potentially increase. What is also critical is how and to what extent the recipient health systems responded to an influx of IDPs, particularly during a period of major structural change due to the implementation of health decentralisation

Coordination of health programmes and services with other sectors including NGOs was an important issue in a health system where numbers of IDPs were seeking health services. The existing health services had to deal not only with the arrival of large numbers and the extended stay of the IDPs but also to form a working relationship with other health agencies which arrived shortly afterwards.

Any possible weakness of the local health authorities in terms of providing better programmes and services according to the health needs of IDPs and their experiences in receiving health services would be identified.

The conceptual framework for a research study influences the choice of an appropriate method (Maxwell & Loomis, 2003; Smyth, 2004). The mixed method was chosen for this study. The product of this research is intended to assist in strengthening the local health system and so contribute to health development for the IDPs as a vulnerable group.

Bridging the gap that existed between the health authorities, particularly the local health authorities and the IDPs, in terms of providing health programmes and services is a product of this research and can contribute to the health development for IDPs.

4.4 Research Design

Research design is the plan, structure, and strategy of investigation conceived so as to obtain answers to research questions and to control variance (Kerlinger and Pedhazur, 1973). The design of this research is to show how all the major parts of the research, including the samples and methods of assignment, build the research. Research design is important in order to make the research explicit, consistent and allow critical evaluation before the research work commences. Research design for this research was developed following the steps depicted in the figure to be found in Appendix D.

4.5 Methodology

A mixed methods approach to data collection was chosen for this research. Both a quantitative and a qualitative approach were used in order to answer the first four research questions outlined in the introductory chapter, the first of which was: what are the key health needs of the displaced population in two selected recipient areas in Indonesia, a municipality and a district? The qualitative method is outlined first, followed by the quantitative method.

The second was: what are the problems experienced by services in the municipality and district in seeking to meet these needs? The experience of the health services for IDPs was explored by qualitative methods.

The third was: to what extent has the public sector identified and responded to the health needs of the IDPs in the context of the health decentralisation policy that was currently being implemented in these two areas? This was explored by qualitative methods also.

The fourth was: on the basis of the preceding analysis, what are appropriate recommendations for the provision of health services to the displaced populations of Indonesia? This was presented in the conclusion and recommendation chapter of this thesis.

4.5.1 Mixed Methods Approach

Mixed methods research is formally defined here as the type of research where the researcher mixes or combines qualitative and quantitative research techniques, methods, approaches, concepts or language in a single programme of inquiry (Tashakkori and Teddlie, 1998; Rao and Woolcock, 2003). This category of inquiry includes the use of induction (or discovery of patterns), deduction (testing of theories and hypotheses), and abduction (uncovering and relying on the best of a set of explanations for understanding one's results) (de Waal, 2001).

Mixed methods were applied in this research to explore the possible weaknesses or gaps in the provision of better health programmes and services for the IDPs by the local health authorities. The choice of analytical tools in this research is consistent with the conceptual framework of this research (Figure 4.1), which informed the design of the study. According to Miles and Huberman (1994), using both qualitative and quantitative methods or mixed methods enables a researcher to corroborate data from different sources, enhance the richness of the investigation, and meet the challenge of considering views that might not have been considered or encountered.

Qualitative research is described as the non-numerical examination and interpretation of observations, for the purpose of discovering underlying meanings and patterns of relationships. Qualitative implies an emphasis on processes and meanings that are not rigorously examined or measured (if measured at all), in terms of quantity, amount, intensity, or frequency (Denzin and Lincoln, 1994). The major characteristics of qualitative research are induction, discovery, exploration, theory/hypothesis generation (Sarantakos, 1997; Johnson and Onwuegbuzie, 2004). Qualitative methods in this research are designed particularly to gain insight into the processes and events that led up to the observed variation i.e. the IDPs' living situation in temporary accommodation in terms of their health problems and access to and utilisation of heath services, the experiences of the health systems and policy in both field areas, also how the public

sector identified and responded to the health needs of the IDPs in the context of the health decentralisation policy.

Quantitative research is defined as the numerical representation and manipulation of observations for the purpose of describing and explaining the phenomena that those observations reflect (Babbie, 1992). Quantitative research emphasizes the measurement and analysis of causal relationships between variables, not processes. The major characteristics of quantitative research are deduction, confirmation, theory/hypothesis, explanation, prediction, standardized data collection and statistical analysis (Sarantakos, 1997). The quantitative method in this research identifies the correlates associated with one health issue variable that was 'illness' at one specific moment in time.

The quantitative approach of this research conceptualized the variables and the relationships between health issue variables that was described as 'illness' at one specific moment in time, while the flexibility of qualitative approach was used to obtain the respondents' perspectives on their health issues and to study their life experiences of health services during the time they lived in temporary accommodation.

Mixed methods research or mixed research can be integrated in three different ways; namely parallel, sequential and iterative (Tashakkori and Teddlie, 1998; Rao and Woolcock, 2003). For clarity this study used the parallel approach in which the qualitative and quantitative methods advance separately, but the findings are discussed together.

Mixed methods offer advantages through the use of words, pictures, and narrative to add meaning to numbers;

- they answer a broader and more complete range of research questions
- they provide stronger evidence for a conclusion through convergence and verification of findings
- they add insights and understanding that might be missed when only a single method is used

- they increase the generalisability of the results and combine the qualities of qualitative and quantitative research to produce more complete knowledge necessary to inform theory and practice (Johnson and Onwuegbuzie, 2004).

In using the above principles the researcher collects multiple data by using different strategies, approaches, and methods in such a way that the resulting mixture or combination is likely to result in complementary strengths and non-overlapping weaknesses. Thus, it was hoped to overcome some of the weaknesses or intrinsic biases and the problems that come from the use of a single method. For example, the questions not covered by the structured questionnaire were discussed in the focused group discussions and addressed by direct observation in order to get valid information.

As Rocco and colleagues stated, "mixed methods increase the validity and interpretability of the research, widen the scope of inquiry and extend the breadth and range of the study through triangulation and add depth and breadth to results and interpretations" (Rocco *et al.,* 2003: 22-23). Triangulation is defined as a research approach employing more than one method of data collection and analysis (Sarantakos, 1997). Triangulation in this research used different methods with the same unit of analysis to research the same issue. For example, a direct observation of the characteristics of temporary accommodation for IDPs was followed by a focus group discussion with the respondents on the same topic, thus cross-checking one result against another and increasing the reliability of the result. This approach increased the chances of controlling, or at least assessing, some of the distortions that could influence the results. In addition, it could provide the strongest effect where the quantitative are grounded in and reflective of, the qualitative data.

Consistent with the chosen methodology, this form of research is more than a simple collection of both quantitative and qualitative data; it indicates that data will be integrated, related, or mixed at some later stage of the research process.

4.5.2 The Activities

This research activity was conducted from September 2002 – August 2006 when the conflicts in Central Kalimantan and North Maluku province were over and the health decentralisation policy had started to be implemented.

This research was conducted in three key stages. First, conducting a literature and document review to give background and context. Second, preparation of data collection tools such as constructing a survey instrument (a structured questionnaire), a protocol for focus group discussions and questions for semi structured interviews that sought to determine issues relevant to the participants' situation. Third, determine the field areas. Fourth, data collection using survey, focus group discussion and semi-structured interviews and direct observation, to obtain a grounded understanding of issues.

The formulation of the research questions was based not only on knowledge gained from being a native of the country of Indonesia, but also from being employed in the public health sector there for over 12 years. This included experience of working in *puskesmas*, the PHO as well as the MoH. Experience in the Research Institution for Health Service Research and Technology Development in Indonesia provided a background of research which was of use in this study.

The study involved the following research activities: determining the existing situation or current health issues that were perceived to be important by both the IDPs and the public health providers in two field sites in Indonesia; determining the research questions and objectives; reviewing literature and documents; determining the area and samples; conducting a pre-survey visit; deciding on the research design; gaining ethical approval, trial and revision of the questionnaires, collecting the data; coding and entering the data; analyzing and interpreting the data; drawing conclusions and making recommendations. The relationship of these elements is represented schematically in Appendix E.

4.5.3 Literature and Document Review

The purpose of a literature review in this research was to convey what knowledge and ideas had been established on issues relevant to the topic of this research, and their strengths and weaknesses. Literature searches were carried out in the following areas: health needs and IDPs' health needs, health systems; conflicts and their aftermath; the causes of ethno-religious conflicts and post-conflict situations in Indonesia, including the impact on and response of the public sector; decentralisation policy and health decentralisation policy. Searches were also carried out on a combination of the above, for example, conflicts and health systems, decentralisation and conflict or post-conflict settings. Literature searches focused on literature published from 1990 – 2007, but where there were references within this material to relevant literature outside these dates these were also explored where possible. Literature searches were conducted using several academic resources, for example electronic journals such as "Emerald Full Text", "CINAHL Plus" (via EBSCO Host Research Databases), "BHI British Humanities Index" (via CSA), "BioMed Central", "IBSS International Bibliography of the Social Sciences" (via Ovid), "Pre-CINAHL" (via EBSCO Host Research Databases) and "Google Search Engine". Similar subject searches were carried out in several academic catalogues. Literature searches and reviews were concentrated into the first year of research, although they were continued throughout the period of research study.

Together with the literature review, document review was also conducted in this research. Document review is the examination of official or semi-official documents such as official government reports and statistics, assignments, lecture notes, and course evaluation results in order to identify instructional needs and challenges and describe an instructional activity. It can be a source for research (Bowling, 2002). Document review in this research used documents that related to health particularly health programmes and services produced by public health sectors, donor agencies and NGOs.

The purposes of reviewing of the documents was to assess the level of the commitment of the public health sector in terms of developing the health programmes and services,

and gather contextual information about those programmes that could be compared with other findings in order to address the research questions.

Data extracted from documents were analysed by content analysis and manual categorisation. Content analysis infers specific characteristics from the documents related to these particular issues. The focus was on the health regulations, policies on the health programmes and services in Indonesia, North Sulawesi and East Java provinces, Manado Municipality and Sampang District and *puskesmas* reports.

4.5.4 Survey Interview

The survey is a method of collecting information from a sample population, usually by face to face interview. The focus of the survey is usually the individual or unit of organisation. A major advantage of the survey method is that it may be carried out in natural settings. It allows statistical inferences of interest to be made in relation to the broader population and thus allows generalisations to be made. In this it increases the external validity of the research (Sarantakos, 1997; Bowling, 2005). This research used structured interviews based on normal interview procedures and an organised interview guide. A structured interview is in reality a questionnaire read by the interviewer/researcher as developed by the researcher.

In this research information from participating IDPs was collected using a structured questionnaire. Through determination of sample size and selection of sample unit for survey interview, the household was used as the unit of analysis in the survey, with the Heads of households being taken as the representative members.

i. Designing the Structured Questionnaire

The content of the questionnaires was consistent with the research questions and was concerned with facts and the opinions and attitudes of the IDP respondents. Some of the questions were related to previous questions and included ideas from the respondents involved in the piloting of the questionnaire. In addition, the questions were designed to

be sympathetic to their level of familiarity with the topics, and also use the minimum of complex terminology.

The questions in the structured questionnaire were grouped and ordered in relation to the data being sought. It included some closed questions such' yes' or' no', also some open questions, multiple questions and ratings (Sarantakos, 1997). The respondents were asked to provide information about their demographic background, length of stay in temporary accommodation, the size of their households, also the characteristics of the temporary resettlement and their access to public health programmes and services offered by the public health sector.

The indicators of health status such as morbidity, disability and mortality were examined by the questions in the questionnaire in order to ascertain the health needs of IDPs. Morbidity in this survey was explored by looking at the incidence of illness among the IDP household members, the causes of it and which persons in a household were affected. The survey also looked at the treatment sought by IDPs, more specifically the kind of treatment. Disability in this survey was investigated by looking at its causes and which members of a household were disabled. Mortality among the IDPs during the temporary resettlement period was examined by looking at the number of family members who had died and the causes of death.

In the structured questionnaire, the method used to measure health status, particularly the incidence of illness was to question respondents about their perception of their overall health and their self-reported general health status. According to Bowling (2005), it is widely recognized that health is multi-dimensional, reflecting the combination of factors that include physical, mental and social well-being, genotype and phenotype influences as well as expectation and information. Thus, the design of the questionnaire also was focused on the determinants of health of the IDPs, their responses to illness, their access to and utilisation of the health services, particularly essential health services provided by the local health authorities through the health facilities. In order to have information of the availability of food, the food security of IDPs was explored through

questions on the availability of and access to food. The structured questionnaire is to be found in Appendix F.

ii. Designing the Semi-structured Questionnaires

As with the structured questionnaire, the design of the semi-structured questionnaires was consistent with the research questions. All the questions in semi-structured quesionnaires were open. The content of questions was related to governance of health programmes and services, accountability and the ongoing progress of health decentralisation.

4.5.5 Semi-structured Interviews

The semi-structured interview is one of the most frequently used qualitative methods. Semi-structured interviews are guided conversations where broad questions are asked, which do not constrain the conversation, and new questions allowed to arise as a result of the discussion. A semi-structured interview is therefore a relatively informal, relaxed discussion based around a predetermined topic (MSP, 2004). Before conducting the semi-structured interview an interview guide is designed to provide a framework and sequence for the topics on which information is being sought. This helps to keep the interview process on track and ensure that important issues related to the topics were addressed (Guion, 2001). In essence, semi-structured interviews in this research involved not only asking questions, but the systematic recording and documenting of responses combined with probing for deeper meaning and understanding of the respondents' responses.

In this research the semi-structured interview method was the technique used to explore health programmes and services and the outcomes of these from the health manager's perspective. The interviews were to capture their thoughts regarding the current health systems, policies, programmes and services provided by them for IDPs. It was believed that the Heads of the institutions had the most comprehensive knowledge of the health issues in the municipality, district and sub-district.

4.5.6 Focus Group Discussion

A focus group is a group discussion that gathers together people from similar background or experiences to discuss and explore a particular set of issues. It offers information about spontaneous feelings, reasons and explanations of attitudes and behaviour as adequately as any other method (Sarantakos, 1997). Focus groups indicate the range of the community's beliefs, ideas or opinions, and are especially valuable for gaining baseline information for a research. Focus groups are used either as preliminary research leading to qualitative research (McQuarrie, 1996), as a self contained and principal method of research, a supplementary source, or as part of a multi-method or mixed methods research (Morgan, 1997).

The reasons for conducting the focus group discussions with selected IDPs were: firstly, to discuss the respondents' health problems during the period they lived in temporary accommodation. Secondly, to allow the participants to agree or disagree with each other and so provide an insight into how the groups thought about an issue, the range of opinions and ideas, and the inconsistencies and variation existing among the IDPs in terms of their beliefs, experiences and practices in health. Thirdly, to clarify and explore further the areas that could not be fully explained using structured questionnaires, especially the range of opinions/views on health issues and services offered by the public sector. Fourthly, to identify their use and access to and utilisation of the health services offered by the local public sector, and to identify whether the health services for IDPs were in line with the local health authority's health programme plans.

In sum, to allow the members of the focus group to express their ideas spontaneously, allowing them to give useful insights into perceived health needs, the quality of health services in the public health sector and their understanding of their health issues.

Preparation for focus group discussion sessions was carried out by the researcher through identifying the main objectives of the meeting, developing key issues, constructing an agenda and planning how to record the session. The protocol for focus

group discussions on issues related to these topics was also developed. The protocol can be found in Appendix G.

Purposive sampling was used to identify participants for inclusion i.e. participants were selected in a deliberate way, with a purpose or focus in mind (Punch, 1998). In this research the participants for focus group discussion were chosen as they were familiar with health issues and usually contacted regarding the health programmes offered by the public sector. They were the informal leaders of the IDPs, the representatives of elderly people, the representatives of Heads of households, the representatives of the women and the representatives of the youth in the temporary resettlement areas.

4.5.7 Direct Observation

Direct observation is defined by Bowling as "a research method in which the researcher systematically watches, listens to and records the phenomena of interest. Observation is not limited to watching but extended to the direct gathering of information by the researcher using the senses, generally both sight and hearing" (Bowling, 2005: 358). Observation, if carried out in a structured and disciplined way is one of the purest forms of research, as it taps directly into behaviour, rather than perceptions, secondary or self-reports of behaviour. It avoids many sources of error (Gabrielatos, 2004).

Direct observation in this research was used to gain an understanding of the situation of those IDPs living in temporary accommodation. Moreover, direct observation gave information on what the IDPs actually did and what the real situation was in the temporary resettlement area in terms of the standard of living. The purpose of this direct observation was to identify the living condition and environmental health problems being experienced by the occupants of the temporary accommodation.

4.6 Field Research

Choice of a field area was most important because the research related to a post conflict period, so the chosen area had to be accessible to such research. The implementation of methods for field research was undertaken in Indonesia as detailed below.

4.6.1 Determination of Field Areas

As explained in Chapter One, Manado and Sampang were the chosen areas. This choice was based on a convenience sampling. According to Israel (2003) convenience sampling is that in which a unit is self-selected or easily accessible. Although this type of sample can yield useful information, the sample must be used with caution in inferring impacts of a programme.

Manado is the municipality that received IDPs from Maluku Utara province because of a religious conflict. Sampang is the district that received IDPs from Central Kalimantan because of an ethnic conflict in that province. In addition, the choice of field areas was based on the presence of IDPs; the need to study both a municipality and a district in terms of contrasting the health systems in handling the IDPs in the different structures of government where Manado is an urban area and Sampang is a rural district. Also these two places were accessible to the researcher in terms of security and access to conduct interviews.

4.6.2 Ethical Considerations

Ethical approval was sought through the Indonesian Health Research Committee which takes responsibility for ethical research. The Indonesian Health Research Committee ensures that all research involving human participants conforms to the highest ethical standards according to the Indonesian perspective. If any researcher wishes to undertake a health research project involving investigations on human participants, the investigator must obtain the Research Ethics Committee's approval before commencing.

The proposal for this research was submitted to and reviewed by the Indonesian Health Research Ethics Committee. A letter of ethical approval was released by the committee in order to conduct the research. The letter of ethical approval is to be found in the Appendix H.

4.6.3 Field Implementation

Eleven months of field work were conducted in Indonesia from October 2003 to August 2004. The field work started in Jakarta with the presentation of the proposal and the questionnaires to the Health Research Committee at The National Institute of Health Research and Development. In Indonesia, if someone wishes to conduct research, particularly in the health field, he or she is required to obtain permission from the government. The researcher is required to present the research protocol to the Health Research Committee before scientific clearance is granted. The committee reviews the proposal, and if it is approved and the research passed then the letter of approval is issued to enable the research to commence. After approval by the Health Research Committee the committee evaluates the progress of the research regularly. When the research project is finished the researcher must submit the results of the research to the committee (NIHRD, 2003).

The members of the committee are representatives of the national university, health programme developers from the Ministry of Health and health researchers with health systems expertise. Their recommendation was to support the proposal for this research, because its methodology, research questions and objectives were related to the situation in Indonesia.

Several suggestions were made by the committee regarding the implementation of the research in the field areas. Because this research is related to the health system and post conflict situations, the committee suggested that specific local issues, such as the social and cultural traditions of the IDPs and the local community, local politics, ethnicity and religion in the field areas be considered.

Communication by letter from The National Institute of Health Research and Development Office to the Provincial Health Office (PHO) in North Sulawesi and the Provincial Health Office in East Java Province facilitated the granting of permission to conduct the field research in the two areas selected. The North Sulawesi PHO contacted the Manado MHO and the East Java PHO contacted the Sampang DHO as the local health authorities and informed them of the purposes of the research. Subsequently, the

Manado MHO and Sampang DHO instructed the *puskesmas* in sub-districts to facilitate the research. Access to the IDPs in both field areas was facilitated through the M/DHO.

Prior to the field research a pre-survey visit was made to Surabaya, the capital city of East Java province and then to Sampang District. These visits were repeated in Manado, the capital and Bitung Municipality in North Sulawesi province. The purpose of the pre-survey was to gain more understanding of the situation in the field research areas and to introduce the purpose of the research to the health authorities in the provinces, district and the municipalities. A pre-survey visit to the selected fieldwork areas allowed some investigation of the areas' geography, social norms, politics and customs; it also served to establish the exact number of IDPs remaining in the municipality and district and to make contact with the local health authorities. A list of the programmes that the Municipality and District Social Welfare Office offered to the IDPs was obtained as was a list of the IDPs in both areas. Accompanied by officers from the M/DHO, a visit to the Municipal and District Social Welfare offices was made in both field areas and the purpose of the research was explained. The IDP sections in the offices were also visited and the persons-in-charge contacted.

4.6.4 Piloting of the Structured Questionnaire and Semi-structured questionnaire

According to Sarantakos (1997) "pilot research serves many purposes: to estimate the cost and duration of the main research and test the effectiveness of its organisation; to test the research methods and research instruments and their suitability; to estimate the level of response and form of drop-outs; to gain information about how diverse or homogeneous the survey population is; to familiarise the researcher with the research environment; to give the researcher and assistant the opportunity to practice research in real situations and before the main research begins; and to test the response of the subjects to the method of data collection, and through that, the adequacy of its structure" (Sarantakos, 1997: 293).

The important of piloting the questionnaire in this research was to check that the design of the questionnaire works in practice and to check that the questions were easy to

understand for the respondents and that the sequence of questions was logical. An additional reason for piloting the questionnaire was to learn the respondents' reactions to the survey.

Prior to the actual fieldwork, the structured questionnaire was piloted with ten IDPs who lived in Bitung municipality. Bitung is a municipality near Manado and is also one of the recipient areas of IDPs from North Maluku province in North Sulawesi Province. In 2002, the number of IDPs in Bitung was 14,113 (Satkorlak Sulut, 2003).

The semi-structured interview questionnaire was also piloted on the health worker in Bitung MHO who was in charge of the IDPs' health programmes and services and on one health worker in the *puskesmas*.

In piloting the structured questionnaire, it became clear that the structure of the questions did not strongly motivate the respondents to communicate and made it difficult for them to recall their experiences – either because they felt that the topic was not important to them or because their experiences were not sufficiently recent for vivid recall. Following this pilot, the questionnaire was revised, starting with narrower questions which were easier to answer by the respondents. The order of the questions was changed, related questions to the sub-topics of the questions were added and non-related questions omitted. The questions were re-grouped and re-formatted to improve flow. For example, a question on maternal and child health was re-grouped with questions on family planning. After the format of the questions was determined, consideration was given to the order in which the questions were placed in the questionnaire.

A logical sequence for the semi-structured questions facilitated respondents' understanding of the questions and, hence, their replies.

4.6.5 Sampling Procedure for Survey Interview

i. Determination of Sample Size

Inclusion of all the IDPs in the two field areas was not possible because of the large numbers. Therefore a sampling procedure was developed in order to obtain a representative sample size. Sample size is the total number of sample units taken from a population of interest for analysis.

Bryman pointed that "the decision about sample size is not straightforward: it depends on a number of considerations and there is no one definitive answer. This is frequently a source of great disappointment to those who pose such questions. Moreover, most of the time decisions about sample size area are affected by considerations of time and cost" (Bryman, 2004: 97). Determining sample size is a very important issue because samples that are too large may waste time, resources and money, while samples that are too small may lead to inaccurate results. The logic of determining the sample size is that the researcher analyses data collected from the sample, but wishes to make statements about the whole target population from which the sample is drawn (Punch, 1998). The purpose of determination of sample size was to draw conclusions about the target population from the sample.

There are several approaches to determining sample size (Israel, 2003). In the process of selecting a suitable sample of the IDPs for the survey, sample size through statistical estimations for proportions was used (Sarantakos, 1997). It was necessary to take into consideration that the population was very large.

This research used a simple technique employing the following formula, which seeks to ensure that a true measure of a given population proportion is estimated.

$$\text{Sample size} = \mathbf{pqZ^2/E^2}$$

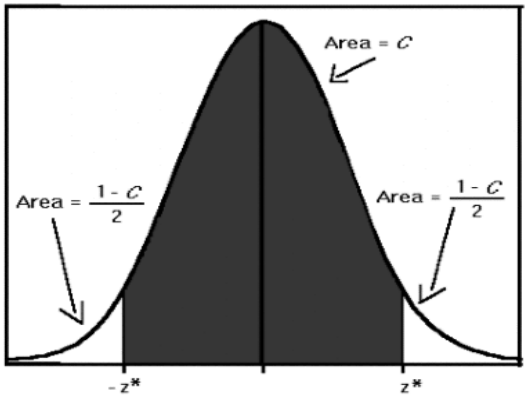
p is the proportion with illness

q is the proportion without illness (1 – p)

Z is the standardized normal deviation for commonly used confidence levels

E is the precision, measured as one-half length of the desired confidence interval (C) (Sarantakos, 1997).

A confidence interval gives an estimated range of values which is likely to include an unknown population parameter, the estimated range being calculated from a given set of sample data (StatLab, 1997). Common choices for the confidence interval are 0.90, 0.95, and 0.99. These levels correspond to percentages of the area of the normal density curve. For example, a 95% confidence interval covers 95% of the normal curve - the probability of observing a value outside of this area is less than 0.05. Because the normal curve is symmetric, half of the area is in the left tail of the curve, and the other half of the area is in the right tail of the curve (ibid).



C	α	α/2
= 90%	0.10	0.05
= 95%	0.05	0.025

The researcher decided to choose the confidence interval that was 95%. The 95% confidence interval refers to the area in each tail of the normal density curve is equal to 0.05/2 = 0.025 and the constant value of Z derived from the standard normal distribution table was 1.96.

In this research, the selection for the sample from the target IDP population was characterised by two distinctive considerations. Firstly – respondents had to be a household, not individuals because the unit of analysis for the structured questionnaire was the household. In this survey a household was defined as two or more people residing together in temporary accommodation. Secondly – they had to live in one of the selected areas; Manado Municipality in North Sulawesi Province or Sampang District East Java Province.

The researcher used the question “has a member of this household experienced an episode of illness in the recall period?” as the basis of the sample size calculation and estimated that approximately 50% of households would give an affirmative response. Hence the sample size calculation was as follows:

$$n = \frac{0.50 * 1 - 0.50 * 1.96^2}{0.05^2}$$

$$\frac{0.50*0.50*3.84}{0.0025} = \frac{0.96}{0,0025} = 384 \text{ households}$$

In order to estimate the proportion of households in the Manado Municipality and Sampang District reporting a member of the household experiencing an illness in the recall period separately, the researcher should have sampled 384 households in each area. However, he acknowledges that the initial calculation of sample size was incorrect and realises that the resulting sample size was too small and may not detect a significant effect during the statistical analysis, even if that effect was truly present. The actual sample sizes used were 71 in Manado Municipality and 116 in Sampang District.

ii. Selection of the Sample Unit

The number of IDPs in Manado Municipality was 9,000 persons, spread over 9 sub-districts (Satkorlak Sulut, 2003; Global IDP, 2004) distributed in the temporary accommodation and outside temporary accommodation. They were concentrated in Mapanget Sub-district and were accessible for interview. The number of IDPs in Mapanget was 1,648 persons; 1,486 lived in brick houses and 162 lived in the Kitawaya Building in Mapanget Sub-district (Dinkesos Manado, 2003).

The number of IDPs in Sampang District was 73,257 persons spread over 12 sub-districts. The IDPs were more concentrated in the hamlets of 3 sub-districts i.e. Ketapang, Banyuates and Robatal and accessible for interview. The total number of

IDPs in Ketapang Sub-district was 13,895, in Banyuates sub-district it was 12,370 and in Robatal sub-district it was 13,745 (Dinkesos Sampang, 2003).

The selected sample in Manado in Mapanget, a sub-district of Manado Municipality, was 71 households. In Sampang it was 41 households in Ketapang, 43 in Banyuates and 32 in Robatal, all sub-districts. The total sample for Sampang District in this research was 116 households, comprising the sum of the sample in the 3 sub-districts.
In this research the respondent was the Head of the household. This was the person, male or female, in charge of the household who declared they were "responsible for the economic and financial choices of the household" according to the social customs of the IDPs.

Nth name selection technique (Sarantakos, 1997) was using to decide on the sample. With this method every Nth recorded household through systematic random sampling is selected from a list of IDP households until the desired sample size is achieved.
The sampling process ensured that every IDP household in these areas was equally likely to be selected.

The steps for household sample selection are illustrated below, using the 41 households of Ketapang sub-district as an example. Firstly, calculate the sample interval (**I)** using the formula:

$$\mathbf{I} = \frac{N}{R} = \frac{3{,}474/4 = 868}{41} = 21$$

N = the number of total internally displaced person households in sub-district

R = the number of households selected

Secondly, consult the list of IDP households in the sub-district. Thirdly, identify the starting point of systematic sampling (R_1); the first value must be less than the interval (**I**); that is, between 0 and 21. Fourthly, calculate the next value (R_2 R_3, R_4, R_5, ... R) by using formula $R_2 = R_1 + I$ and finally circle the numbers selected.

The process was repeated until the selected number was reached. In situations where the respondent was not to be found or was not prepared to be interviewed, an alternative was selected, based on the next number on the list who was willing to do an interview. The same process was used in both research sites.

Before the survey interviews, a meeting was arranged in both field areas with the formal and informal leaders of the respondents. After introductions the purposes of the visit were explained and what was hoped to be gained from the research. After permission was obtained from them, the surveys were conducted with the selected respondents.

In Manado, an IDP was hired to assist in finding those on the selected respondent list provided by the Municapal Social Welfare Office. Similarly, in Sampang, an IDP was hired to interpret the local language (Madurese) and assist in finding the selected respondents' residences from the IDP list provided by the District Social Welfare Office and the DHO. To ensure full understanding of the questions by the respondents in Manado and Sampang, the research objectives and the approach to the questionnaire were translated into the national language, Bahasa Indonesia by the researcher.
In Sampang the interviews were translated into the local language (Madurese) through an interpreter and used on a few occasions when respondents spoke only Madurese, he translated the responses into Bahasa Indonesia and the researcher then translated them into English. The interpreter also translated the questions and responses in the focus group discussions. This was occasionally necessary when the respondents spoke and understood best in Madurese.

In both field areas the respondents were interviewed in their temporary accommodation which could be in a building, brick houses, barracks or houses built on relatives' land. At the start of each interview a protocol of introductions, explanation of the background of the researcher and information on what would happen to the information provided by the respondent was followed. Care was taken to ensure informed consent from the respondents and an assurance of privacy was given. Eyber revealed that "in a society characterised by violent conflict, suspicion and fear are a common reaction to outsiders" (Eyber, 2001: 101).

The researcher reassured the respondents by being honest and open about himself, his background and the constraints of his research as well as the possible benefits which would be not only for them but also for other IDPs living in other parts of Indonesia. Finally they were asked to sign or stamp (using ink) with their thumb the statement of agreement, to confirm that they had agreed to the interview. The Statement of Agreement is to be found in the Appendix I.

The qualitative methods used in this research were focus group discussions, semi-structured interviews and direct observation. These were complemented in the field by a review of NGO and government documents (articles, annual reports and health profiles).

4.6.6 Semi-structured Interviews

Semi-structured interviews were conducted with a fairly open framework which allowed focus on the issues through two-way communication between the researcher and respondents. Semi-structured interviews with the Head of Manado MHO and the Head of Sampang DHO were conducted in the health offices. Semi-structured interviews for the eight Heads of *puskesmas* were conducted in the *puskesmas* office in the 2 (two) *puskesmas* in Manado Municipality namely *Puskesmas* Bengkol and *Puskesmas* Paniki Bawah, and in the 6 (six) *puskesmas* in Sampang District namely *Puskesmas* Ketapang, *Puskesmas* Bunten Barat, *Puskesmas* Banyuates, *Puskesmas* Bringkoning, *Puskesmas* Robatal and *Puskesmas* Karang Penang.

During the interviews, permission was sought from the interviewees to tape record the interview and take notes. All respondents agreed. Overall the length of semi-structured interviews ranged from 45 minutes to one hour.

4.6.7 Focus Group Discussion

In both field areas identifying and inviting suitable participants for the focus groups was done by consulting the informal leaders of the IDPs in the temporary accommodation compounds. These leaders were then invited to lead and take part in the focus group

discussions. Occasionally the researcher helped the leaders to explore some questions in more detailand specific issues related to health that were missed by the participants.
In the temporary accomodation area in Mapanget, Manado Municipality, one focus group discussion with seven participants, was conducted. The participants were one elderly person, one Head of household, two housewives, two young men and one informal leader of the IDPs.

In Sampang District focus group discussions were conducted one in each selected sub-district. In Ketapang sub-district, the focus group was conducted in the barracks and the group consisted of seven participants: one informal leader of IDPs, two Heads of households, one elderly person, two housewives and one young man. The focus group in Banyuates sub-district met in a house and had seven participants: one informal leader of IDPs, one elderly person, two Heads of households, one pregnant woman, one housewife and one young girl as group members. In the focus group in Robatal sub-district also met in a house, there were seven participants: one informal leader of IDPs, one elderly person, three housewives (one of whom was pregnant), one teenage girl and one young man.

Each focus group discussion started with introductions and explanations of the purpose of the discussion. During the process of discussion the researcher ocasionally realised that the informal leaders were dominating and made efforts to encourage the other participants to be active and involved.

Data gathered from focus group discussion was recorded by using a tape recorder and by taking notes, after seeking permission from the members of the focus group. A summary page was created after each discussion, indicating the issues related to their health problems that had been discussed. The data from tape recorder was then recorded on the computer using *Microsoft word* software**.**

4.6.8 Direct Observation

It was possible to observe the conditions in the in the recipient areas by walking around the temporary accommodation and surrounding environment making direct observations by inspection of the accommodation and the surrounding area, recording the IDPs' hygiene and sanitation and making "field notes".

During the field research, the researcher recorded his impressions through hand-written notes related to the objectives of the study and possible data that might answer the research questions and to clarify his observation objects. He also took photographs in order to remind him of the objects and environmental contexts in the field areas. The data collected from direct observation were merged with the other qualitative data for analysis.

4.7 Checking the Bias in Data Collection

Data collecting from the field research through survey questionnaire, focus group discussion and semi-structured interviews in this research could have been influenced by either the context of the study, the respondents themselves, or the researcher. This situation is known as bias in data collection. According to Nigel (2004) the term "bias" is technically meaning "leaning" in one direction, it is often used to refer to respondents or researchers having pre-conceived ideas or an ideological disposition. It is important to understand that bias is inevitable and normal (Nigel, 2004). The problem is not the presence of biasing factors, but that the writer seems unaware of them, and interprets interview or questionnaire data as a "true account" of reality. This can lead to exaggerated claims based on the data (ibid). The bias could also influence the data gathered from field research, and can contaminate the portrait of either respondents' behaviour or their attitudes and beliefs.

In this research bias in the data collection was handled through checking and rechecking the validity of the information. Questions that the respondents did not understand were explained by the researcher giving an example. In addition answers that the researcher considered possibly unreliable were compared with those from other respondents. This

procedure helped to minimize bias from respondents during the data collection. As noted in the section 4.6.7, FGDs were conducted through mixed groups – bias could be introduced by for example the domination of the discussion by the informal leaders and the shyness of the young girls. Bias in this research will be further discussed in Chapter Seven under limitations of the study.

4.8 Coding of the Qualitative and Quantitative Data

The coding process is carried out to summarize, synthesize and sort the different varieties of data. Data coding refers to distinctive means for highlighting different categories of displayed data for user attention (Smith and Mosier, 1997). Coding allowed the researcher to reduce large quantities of information to a volume that could be more easily handled. The coding process is the fundamental basis for the final analysis (Seidel, 1998). Coding process in this research was divided by coding quantitative and qualitative data.

To ensure that all relevant data had been collected, the data cleaning process was done immediately after the interviews finished. The data gathered from focus group discussions, semi-structured interviews and direct observation was documented and stored in both paper form and on the computer.

4.8.1 Coding Qualitative Data

In the coding process significant information in qualitative data was highlighted in order to answer the research questions. The qualitative data recorded from the focus group discussions, the semi-structured interviews and direct observation was transcribed, word repetition by the respondents was edited, non-related information was cut and the required information was sorted then coded. For example, qualitative data from focus group discussion where an elderly respondent gave the same opinions several times with superfluous information had to be edited. The transcripts of focus group discussions are to be found in the Appendix J.

During the process of transcription, critical reflection was taking place on the data gathered from focus group discussions. Themes and important information began to emerge from this clarification. A similar process was using to code the semi-structured interview data collected from the Heads of MHO, DHO and *puskesmas.*

4.8.2 Coding Quantitative Data

The coding process in quantitative data involved coding the structures questionnaire. The purpose was to ensure that the answers gathered from respondents were categorised appropriately.

Quantitative data entry was done using the *Statistical Package for Social Sciences* (*SPSS) Version 13.0*. The process of data entry included control of the validity of data, editing of current information, and proof reading new entries for accuracy before storing them in the database. At the end of the process of data entry the initial entry was rescrutinised and verified.

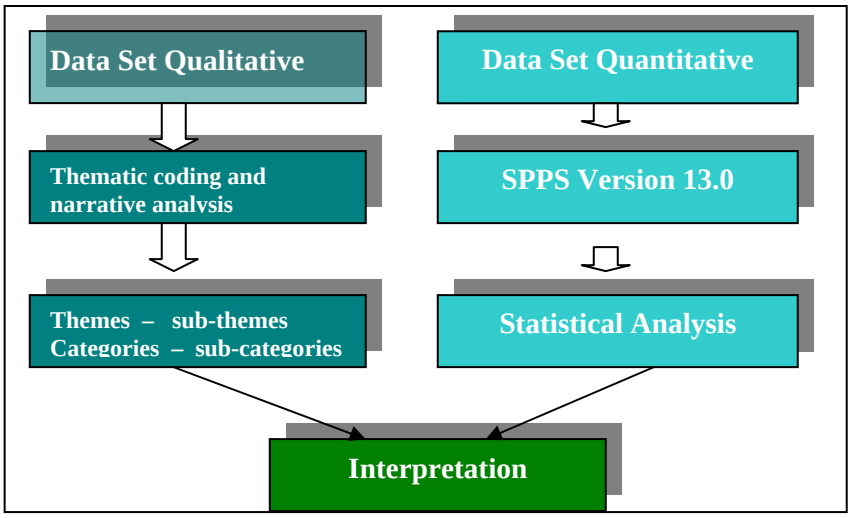
4.9 Data Analysis and Interpretation

Analysis is about the search for explanation and understanding in the course of which concepts and theories will probably be advanced, considered and developed (Blaxter *et al.,* 2001). According to Sarantakos (1997) this stage is known as data reduction and organisation. Data reduction refers to the process of manipulating, integrating, transforming and highlighting the data while it is being presented. Data organisation refers to the process of assembling information around certain themes and points, categorizing information in more specific terms and presenting the results in a cohesive form. Data reduction and organisation helped in the identification of the important aspects of the issues in the research questions and how to integrate the qualitative and quantitative data.

Data analysis was based on the research questions and objectives of this research. In the analysis phase, all the data were summarized and integrated with the purpose of reducing the data complexity to a level where the information could be grasped and interpreted in line with theories and methods identified in the related literature and

documents review. Data analysis was an ongoing reflexive process that began during the phase of piloting the questionnaires, particularly qualitative data, and continued with statistical analysis until the end of writing the thesis. The data analysis process is shown in the figure below.

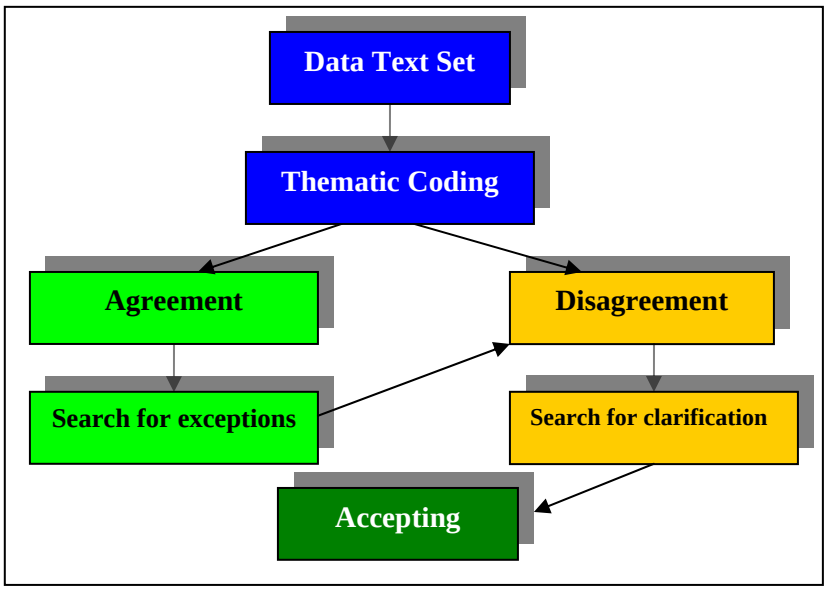
Figure 4.2: Data Analysis Process



4.9.1 Qualitative Data Analysis

Thematic coding was used to analyze through two phases the focus group discussions texts that had been transcribed in both phases. Open coding was the preliminary phase of analysis. At this stage the transcripts were reviewed, identified, and categorized by the descriptions of experiences found in each line, sentence, and paragraph in the transcripts. Secondly, axial coding that was used to relate codes (categories) or to seek connection between the categories identified.

Figure 4.3: Application analysis of qualitative data



The qualitative data in this research was approached through reading and re-reading the textual data in the transcripts from focus group discussions and semi-structured interviews and labelling the categories and their interrelationships. The data text set was then categorised though thematic coding. The example of the themes, sub-themes and categories is to be found in the Appendix K.

In the transcripts important statements in focus group discussion given by respondents were noted and analyzed for the presence, meanings and relationships of words and concepts and inferences were made about the messages within the texts. This process involved close study of the texts, identifying, sorting and highlighting coherent categories related to potential data that answered the research questions. A similar approach was used for analysing semi-structured interview data.

Document reports were analysed by using narrative analysis and the related information generated from the reports in order to answer the research questions.

4.9.2 Quantitative Data Analysis

The analysis of quantitative data was started by analysing the structured questionnaires through coding, indexing and entering into the computer using *SPSS Version 13.0* software followed by checking and cleaning the data. The *SPPS* software provided flexibility and extensive options, particularly for management of the data and its description during analysis and interpretation. In order to support the qualitative data and address the research questions, emperical analytic inquiry was applied in this analysis and descriptive statistics were generated for further analysis.

Chapter Five presents the data findings and analysis.

Chapter Five

The Internally Displaced Persons: Health Needs and Experiences of the Public Health Sectors' Programmes and Services in Manado Municipality and Sampang District

Introduction

In the introductory chapter, the first research question was posed:

What are the key health needs as perceived by displaced persons in Indonesia?

This question was accompanied by several sub-questions:

- What were the general characteristics of the temporary accommodation in the recipient areas, and did the IDPs consider that these characteristics had any bearing on illnesses they suffered during the time they lived in the recipient area?
- How did the IDPs access and utilise the essential health programmes and services offered by the public health sector? Were there any constraints on that access and utilisation?
- What was the relationship between the characteristics of IDPs, particularly those expected to be of determinants of health, and illnesses contracted during the time they lived in the recipient area?

This chapter presents the information obtained from direct observation, the focus group discussions and the survey of the IDPs who lived in an urban area in Manado Municipality, North Sulawesi Province and in a rural area in Sampang District, East Java Province, Indonesia. In Manado Municipality the survey was conducted in March-April 2004 and in Sampang District a similar survey was conducted in May - June 2004.

In relation to the questions above the chapter is structured by first analyzing the qualitative data that were gathered by direct observation and focus group discussion. This included the characteristics of temporary accommodation; the living conditions of IDPs and any challenges due to these situations; the health problems experienced by IDPs; IDPs management of their health problems; the health services available in the recipient IDP areas; their experiences with health services and providers and other issues related to their health.

The quantitative data collected by the survey is analysed and discussed later. In the survey the health status of respondents, certain factors of determinants of health that influenced their health status, their type of accommodation and household allocation, the characteristics of household respondents and the essential health services offered by the public sector in two different areas were explored in order to answer the research questions.

Qualitative Data Analysis

In this research qualitative data analysis provides ways of discerning, examining and contrasting the data from two field areas and interpreting meaningfully the following themes through thematic coding analysis in order to answer the research questions.

Theme 5.1 Reasons for Flight to the Recipient Areas

The IDPs had already lived for several years in these places of safety and they discussed the reasons why they had come to the areas. During the discussion they brought up several issues in relation to their living conditions and the challenges in their situation in temporary accommodation. IDPs in Manado explained that many of them had been moved several times either in Manado or in other districts in Sulawesi Utara province. They finally decided to settle in the temporary accommodation in Mapanget. As respondents commented:

> *"…after the riots we came directly from North Maluku province to Manado City, because we thought this area was safe for us. We already lived in several places before we came to the temporary accommodation here in Mapanget Sub-district"* (Eldely male, Mapanget).

IDPs in Sampang district had had similar experiences. Many of them had stayed in other places including other provinces and finally decided to live in this district. As the respondents said:

> *"…we came here because our family was living here and our ancestors were from here…we are living in our relatives' house and share the house with them…our family gave us a room, we want to return to our own place but until then we will stay with our family* (Adult female, Robatal).

> *"…when the riot happened, first we lived in the city in Java Island. My family and I moved here because we heard that there were facilities for IDPs supported by the government and NGOs* (Adult male, Banyuates).

Theme 5.2 Characteristics of Temporary Accommodation Areas

In Manado, in 2001, 500 very small houses were built by the Manado local governments (provincial and municipality) and the United States Agency for International Development (USAID) with the purpose of providing temporary accommodation for the IDPs from Maluku Utara Province. The IDP houses were located on the hills and valleys close to the river in Mapanget Sub-district, a distance of about 20 km from Manado City which can be reached by public transport within approximately 30 minutes. The temporary accommodation was isolated from the local community by a distance of about 3 kilometres in Mapanget Sub-district. There are two access roads to the IDPs houses from the city. The first is by the road leading to the Sam Ratulangi airport, passing through a coconut plantation. The second road is through the local community of Pandu Village.

Living conditions in these houses were very simple: 12 meters square, built of brick and cement with zinc roofs (Picture 5.1). They had good air circulation and the development was supported by an infrastructure that including roads, electricity, piped water, water tanks (plastic and cement) and a *pustu* (auxiliary *puskesmas*), but no main drainage. Some IDPs added rooms for kitchen and bathroom. There were simple public latrines or toilets available, but some of the IDPs built toilets attached to the houses. These drained into their own pits that were emptied by the local authorities when they became full.

From direct observation, it was clear that in this relocation area, this temporary accommodation was well situated and the infrastructure was in place. Some of the houses had been well maintained by the IDPs, although a number of houses were run down due to lack of funding for maintenance.

Picture 5.1: The Brick House

In addition to these houses, the Kitawaya building, which belonged to the provincial government and had previously been used for local women's activities, was now used for IDPs' temporary accommodation (Picture 5.2). This building was easily accessible and lay on the main road of the Municipality in the same sub-district. Services such as electricity and piped water were available in this building in addition to communal toilets and bathrooms. Although tidy and clean there was some overcrowding.

Picture 5.2: Kitawaya Building

In Sampang, the IDPs shared the area with the local population and set up temporary accommodation nearby. Other resettlement schemes included barrack type accommodation made available by the local government (provincial and district), central government and non-governmental organisations, and lodging with relatives.

Barracks are non-permanent structures. Some barracks were located near the beach (especially in Ketapang sub-district) and some in wooded areas (particularly in Banyuates and Robatal sub-districts). Houses built on relatives land are non-permanent structures belonging to the host community. Many IDPs houses built on relatives land were located in woodland and some IDPs were separated from their local family.

There are ten official barracks built by the government and NGOs, consisting of 500 rooms in one compound in Ketapang sub-district. The compound is located in the centre of the sub-district's economic activities (Picture 5.3). In addition there were several small barracks built by NGOs in Banyuates and Robatal Districts.

Picture 5.3: The barracks in Ketapang Sub-district

The barracks in Ketapang sub-district were accessible and very well arranged. Electric power and other infrastructures such as roads, wells and water piping, water tanks and bathrooms were attached to these barracks. There were latrines provided by government and NGOs attached to the barracks.

In Banyuates and Robatal sub-districts, there were several small barracks with minimal standards and limited space. These were built by the government and NGOs. In terms of transportation the barracks were accessible, but there was no electric power supply. The other services, such as wells and rain water tanks were available. In contrast to the barracks compound in Ketapang sub-district, the barracks and services in Banyuates and Robatal were not well arranged. Some barracks in all three sub-districts were no longer habitable because of damage and lack of repair. They had had no maintenance since their erection four years previously. The IDPs had moved to their friends' rooms in the other barracks in the same compound that were still intact.

In the houses built on relatives' land in the three sub-districts (Picture 5.4), infrastructure including wells, and rain water tanks were available, but the roads were poor, particularly in Banyuates and Robatal sub-districts.

Picture 5.4: A Typical House Built on Relatives Land

The houses were all located in the same compound with the relatives' houses. They were very small and simple having been built by the IDPs and their relatives. Local materials had been used, such as wood for the walls and locally made ceramic roof tiles or palm leaves or grass for roof coverings**.**

Some of the houses had earth floors and no electric power, but their purpose was to provide short term accommodation.

Sub-theme 5.2.1 Living Conditions of the IDPs

Living conditions are multi dimensional and can play a major role in susceptibility to disease. In this research the living conditions studied were those of IDPs living in temporary accommodation. In Manado, the IDPs were not much concerned about living conditions. As one respondent commented:

> *"we are living at the standard of housing for people with our status as IDPs compared with the previous temporary accommodation and this is enough* (Adult male, Mapanget).

> *"…we live in a very simple house with one bed room and one living room and the floor is made of cement here in Mapanget Sub-district* (Adult female, Mapanget)

In Sampang living conditions for IDPs in this area were generally harsh. There was insufficient space available in the crowded barracks and houses built on relatives land where lodging was rudimentary. As the respondents said:

> *"…I live with my parents in our family's house in the village near the tobacco plantation. The house is very small with an earth floor my brother and I sleep in the living room and because the floor is earth we use "the chop bamboo" for our bed"* (Young female, Banyuates).

Another respondent commented:

> *"…the condition of our temporary accommodation has the potential to lead to diseases because it is too crowded, my family consists of five members and we are living in one room only* (Adult male, Banyuates).

The accommodation in Sampang district was of a very basic standard in terms of housing conditions. Moreover, some of it was situated in rural areas and distant places such as Robatal and Banyuates districts. The difficulties this presented was highlighted by one respondent:

> "*…we lived in the forest area in this district and the condition is not good for us because we have to walk several kilometres to the main road and reach public transport to the market"* (Adult male, Robatal).

Picture 5.5: Living conditions in barracks in Ketapang Sub-district

In Ketapang sub-district some of the barracks had been damaged by a hurricane, as shown Picture 5.6, exacerbating the housing problems. As one respondent said:

> *"…my family and I stayed in the barracks that was built by NGOs, private organisations and government… many of the barracks were damaged because the barracks is already 3 years old and last month several were hit by a hurricane, some of our family and friends who lived there were moved to our families and friends' barracks. The living situation became even more crowded"* (Adult male. Ketapang).

Picture 5.6: The barracks destroyed by hurricane

The crowded living conditions in the safe areas for those who had already lived for some years in the temporary accommodation had the potential for a direct effect on health, particularly in Sampang district. The living conditions varied significantly depending on the location of the IDPs, although in Manado they appeared better than in Sampang District.

Sub-theme 5.2.2 Water Supply and Sanitation

Basic physical infrastructure such as water supply and sanitation are important in terms of physical assets such as water sources, tanks, pipes and sanitation utilities in temporary accommodation areas. If these assets and utilities are lacking, the consequences for IDPs may be waterborne diseases. An on-site review and discussion of the water sources and supplies looked at the IDPs' water systems including the adequacy of water facilities for producing and distributing safe drinking water and water for latrines.

i. Water Supply

In Manado, most of the IDPs in Mapanget had access to clean drinking water, either from the wells that they had built or a piped water system. There were also several plastic water storage tanks and permanent water storage tanks built by the government and NGOs surrounding the relocation area.

Picture 5.7: Well as a drinking water source in Manado

In this same area a river was also used as a water source by the IDPs living in some of the brick houses for washing their clothes, utensils and for showers. The quality of the river water could be seen at a glance, it had a dark colour because the water was mixed with household waste water. No protection or effort had been made to improve the water quality in the river as shown in the picture below.

Picture 5.8: The River near the brick houses compound

Availability of, and accessibility to, water for IDPs who lived in the temporary accommodation, including the water's infrastructure, however seemed sufficient. As one of the respondents commented:

> *"…to find water in this area is easy… we can take the clean water from the well and piped water. To wash our clothes we use water from the river"* (Adult female, Mapanget).

The observation also found that the respondents' access to a water supply reflected their economic status. Those who consumed bottled mineral water and piped water were able to pay for the water. The IDPs who lived in the Kitawaya building obtained water from the well and a pipe provided by the municipal authority.

In Sampang, many of the IDPs had access to clean drinking water from the wells that they built or wells provided for the local community or from the piped water system, particularly in Ketapang sub-district. But some of the IDPs had difficulty in taking baths and washing their clothes particularly those who live in Robatal sub-district. They had to go to a small river, which dried up in the dry season. As one respondent commented:

> *"…The location of our places is far from the water sources…we have to go to the river to wash our clothes. In the rainy season we use the rainwater that we keep in the rainwater reservoirs donated by the NGO*" (Adult female, Robatal).

There were several plastic rain water storage tanks and permanent water storage areas built and provided by government and NGOs as an alternative water source particularly in the rainy season. The water tanks and water storage were well maintained by the IDPs.

Picture 5.9: Water tank in barracks compound in Ketapang Sub-district

Water scarcity was a problem for some IDPs, particularly those who lived in the surrounding woods. They had to obtain water from sources such as wells some distance from their barracks or at houses built on relatives' land. The water supply resources were however clean. Most of the respondents were using water from the public neighbourhood wells.

Picture 5.10: Well in a relatives' house

ii. Sanitation

The term “sanitation”, in this research refers to excreta disposal, solid waste disposal and drainage. In considering the sanitation issue in the temporary accommodation area the availability of latrines was important and also how the IDPs managed the disposal of human excreta.

The most common disorder transmitted through faecal pollution in the household, the community and the environment is diarrhoea. Diarrhoea can be a cause of premature death. Other illnesses include hepatitis A and E, dysentery, cholera, helminth infection and typhoid fever.

In Manado, the health sanitation programme refers to the establishment of environmental conditions favourable to health. From personal observation, public latrines for IDPs, provided by government and NGOs, were available and accessible. Some private latrines could be found in several houses and some IDPs had built private toilets attached to their houses. At the time of observation, the toilets appeared clean and well maintained.

Picture 5.11: Toilet Building in Manado

During the discussion, the IDPs raised issues related to other aspects of sanitation. As one respondent commented:

> *"…garbage produced by IDP households is difficult to handle, we dug several pits for the garbage but the pits are already full and some of households just throw their garbage on the land surrounding their houses* (Adult male, Mapanget)

At first sight, the health environment and sanitation of the temporary accommodation areas both in brick houses and buildings in Mapanget Sub-district was satisfactory. However, waste management was poor due to inadequacy of collection, transport, processing and disposal of waste materials, mainly those produced by human activity. There were a number of refuse pits close to the houses, but they seemed to be full and there was no initiative to dig new pits.

In Sampang, on-site review of the latrines in the barracks and houses built on relatives' land indicated that there were simple latrines available for IDPs who lived in barracks in Ketapang sub-district and there was evidence that the IDPs used them. There were also simple latrines in small barracks in Banyuates and Robatal sub-districts, but the latrines were not well maintained. At the time of the survey the infrastructure of the toilets and latrines were suffering from disrepair.

Picture 5.12: Toilet on Relatives' Land

The IDPs did not appear to use the latrines for defecating. In fact, they defecated in a field near the barracks and temporary houses. The method was to dig a small pit and bury the faeces. Sometimes they were not buried adequately, resulting in greater risk of disease transmission. As the one respondent commented:

> *"…we don't use the latrine that the government and NGOs built for us because there is no water available and also we didn't feel comfortable using those latrines. We went to the bush surrounding the houses for defecating"* (Adult male, Robatal)

The IDPs, especially those who lived in houses built on relatives land in the woods, had latrines, but generally they defecated outdoors and did not cover or dispose of their excreta properly. Garbage management and disposal of waste water were additional problems faced by the IDPs who lived in the barracks. As one IDP commented:

> *"…we find it difficult to handle the domestic garbage, because the pits that we dug are full. In addition, the IDPs who live here throw the garbage every where and they just drain the waste household water on the ground surrounding the barracks*" (Adult male, Ketapang)

Theme 5.3 Health Problems Experienced by IDPs

IDPs are a vulnerable group. Most of the common health problems of IDPs are potentially serious because of their experiences in complex emergencies, their flight and the minimum standard of living in the temporary accommodation.

The health problems among the IDPs were exacerbated by weather and shortage of clean water and sanitation systems in the recipient areas. In Manado, the respondents stated that living in the temporary accommodation had the potential to lead to health risks. As one participant commented:

> *"…living in this area, we also suffer from diseases. Certain types of disease symptoms such as muscle pain, malaria, cold and coughs, are common particularly in the wet seasons* (Elderly male, Mapanget).

Moreover in this municipality the main health problems seen had to do with continuing care of chronic conditions, such as hypertension, as well as psycho-social disorders. As one respondent commented:

> *"…we were suffering from stress. Our experiences in the conflict are very difficult to wipe out from our minds (*Adult female, Mapanget*).*

In Sampang the major health problems were communicable diseases accompanied by stress problems. As the respondents commented:

> *"...most of people who live in this area suffer from several kinds of disease symptoms, particularly colds and coughs which are common particularly during the wet seasons. Being stressed is also one of our problems because of our past experiences and living in this place. In the dry season the occurrence of skin diseases is common* (Adult female, Robatal*).*

The health problems among the IDPs in both field areas were complicated by the prevalent communicable diseases and stress. As illustrated in the discussions, IDPs who were suffering from health problems in both field areas were most susceptible to communicable diseases.

The major health problems reported by IDPs in the temporary accommodation were the symptoms of acute respiratory infections, gastroenteritis, stress, malaria and skin diseases. In response to questions participants said that they had a lot of problems with their health.

Theme 5.4 IDP Health Care Decisions for Coping with Health Problems

Given the post-emergency situation and life in the temporary accommodation, the IDPs generally had to take care of their own health problems and cope with their health through the health resources available in the recipient areas. This responsibility for health care is important because it will explain the nature and effect of the IDPs' decisions and behaviour in health seeking, based on their conditions and health needs.

During the discussion, respondents were asked to discuss their personal views about their response to illness and decision to seek health care, with reference to their perception of an illness affecting them and their household members.

In Manado a respondent commented:

> *"…if we have an illness we buy a drug in the small store in this area, especially if the disease is fever, cough or flu…that kind of illness we feel is not too serious, but if the illness were serious we would go to the health facilities, although we need money to cover the cost of going to the puskesmas or hospital to get treatment* (Adult female, Mapanget*).*

In the discussion, the respondents said they typically took no action until they felt the symptoms became more severe and then decided to go to the health facilities. Some of the respondents, particularly adults, took no action at all. One participant said:

> *"…sometimes we just ignore the diseases because we don't have enough money to buy the drugs"* (Adult male, Mapanget).

In this municipality, the IDPs handled their stress problems by trying to forget their past horrific experiences and getting on with their lives, but they still felt badly if there was a conversation about the conflict events. Some IDPs individually reported feelings of sadness and worry, and this seemed a common picture of IDP's emotional problems. As one respondent said:

> *"…we feel so sad when we remember the conflict in our homeland and the victims who were our family and friends and we try to forget and pray for the rest of our life" (*Adult female, Mapanget*)*

In Sampang, the experience of IDPs in handling their diseases was similar to those in Manado, as illustrated by respondents:

> *"…if we have an illness we buy a drug in the small store in this area, but if the illness were serious we would go to the puskesmas"* (Adult female, Banyuates*).*

> *"…sometimes we just ignore the diseases or we used traditional drugs such as kinds of plants for fever that we can obtain from the traditional healers"* (Adult male, Banyuates*).*

> "*…the past experiences make us depressed, but we have to survive to face our life by doing some activities such as prayer in the mosques*" (Elderly male, Ketapang).

The IDPs did not seek medical care quickly and they did not consider medical care to be an appropriate response to physical pain, particularly those who suffered from mild and moderate disease symptoms.

In both areas, the IDPs choices of health care to cope with health problems varied and depended on the severity of the diseases.They looked for a range of health services from a variety of different providers at all stages of their illnesses.

Theme 5.5 The IDPs' Experiences with Health Services

The IDPs, particularly those who were susceptible to diseases, had two to four years experience of dealing with their health problems in the recipient areas. They had to accept the health services available in the recipient areas and take the initiative to use and reach the health facilities.

In this research, IDPs' experiences with health services covered the availability, utilisation, barriers in accessing the health facilities and their satisfaction with health services. In addition, living in temporary accommodation with limited resources affected the IDPs in terms of coping with illness.

Sub-theme 5.5.1 The Availability of Health Services

The availability of health services in recipient areas directly affected the health and well-being of the IDPs. For IDPs with poor health status, poverty and limited access to a range of health services can be critical in preventing diseases and maintaining the quality of life.

The health facilities that existed in the recipient areas provided health services to the local community and the IDPs. Particularly in *puskesmas* essential health services were the primary health services. In Manado, the essential health services such as Maternal Child Health (MCH), family planning, immunization, nutrition, environmental health and basic medical treatment are available in the health facilities. The range of available health services was illustrated by the respondents who commented:

> *"…the health programmes and services that available in this area as I remember are MCH, family planning and immunization" (*Adult male, Mapanget*).*

> *"...I know… we can have basic medical treatment in the posyandu …including weighing our babies and sometimes our babies have a green bean meal provided by the posyandu* (Adult female, Mapanget).

> *"…health environment services are also provided by the puskesmas, such as controlling the mosquitoes through spraying the lagoon near the river…. because that place is the breeding place for mosquitoes* (Young male, Mapanget).

Respondents in Sampang offered similar comments:

> *"…the health programmes and services offered by puskesmas are MCH, family planning, immunisation, basic medical treatment and health environment. To get the basic medical treatment we have to go to the puskesmas* (Adult female, Robatal).

> *"…the puskesmas officers…came here for the mosquito fogging programme to fog the barracks but that was last year (*Young male, Ketapang).

From the discussions it was clear that the IDPs recognized the range of essential health services provided by the local health authorities in the recipient areas.

Sub-theme 5.5.2 Utilisation of Health Facilities

Utilisation of health facilities in recipient areas is important for indicating ways to improve the management and delivery of health services. The respondents discussed their utilisation of the health facilities available in the areas where they lived.

The experiences of IDPs in using health facilities when a member of their household had an illness were recorded. In Manado the participants commented:

> *"…when my young daughter had a fever, we worried so much and we didn't want to give her just any or trifling drugs that we could buy in the shop…we went to the puskesmas to have a physical examination, treatment from the doctor or nurse for her illness and advice on what we could do for her* (Adult male, Mapanget).

> *"…we almost always used the health post (posyandu). We were using the health facility for pregnant women and the immunisation programme that was conducted by the puskesmas which ran a posyandu regularly in the church building in this compound area* (Adult female, Mapanget).

Respondents in Sampang had similar experience of utilisation of health facilities. A typical comment was:

> *"…the services offered by puskesmas are basic medical treatments. To obtain basic medical treatment we have to go to the puskesmas particularly if we suffered from severe illness"* (Adult male, Banyuates).

As mentioned previously, the adults generally treated themselves with drugs bought from the local stores. If they felt that the drugs did not work, they then went to the health facilities. However, if the infants or children became ill, the parents took them directly to the health facilities or to the private practices of doctors/nurses. One typical comment was:

> *"…if our infant or child becomes ill, we rush him or her to the health facility, if the health facility is closed we will go to the health officer's house to ask for help* (Adult female, Ketapang).

> *"…when my son broke his leg when he fell from a tree…we rushed him to the hospital in Sampang"* (Adult male, Ketapang).

> *"…the puskesmas gave me a simple treatment for the urine stones that I am suffering from and a letter referring me to the hospital"* (Adult male, Banyuates)

Public health workers had also endeavoured to provide routine immunization and other health preventive services in those health facilities, particularly in *posyandu* within IDPs' temporary accommodation so the IDPs could utilise the preventive health services.

In both field areas a number of factors thus affected utilisation of health facilities. The perception and severity of illness influenced the utilisation of health facilities.

The M/DHO provided emergency referral services through every *puskesmas*. In both field area the treatment provided by the *puskesmas* was limited to essential health services and if the IDPs required advanced treatment they had to go to a higher health facility. This made utilisation of health facilities difficult for those IDPs who suffered from severe or chronic diseases which could not be treated in *puskesmas*.

Sub-theme 5.5.3 Key Barriers to Accessing Health Facilities

Health facilities are not often accessed by vulnerable people such as IDPs. Many IDPs households are poor and if they use their limited assets to obtain access to health services they fall deeper into poverty.

In the discussions questions including the cost of health services and the distance to the health facilities when care was needed were explored. In addition to these matters, a core set of essential health services focusing on MCH, family planning, immunization, nutrition, environmental health and basic medical treatment for some health services were related to post-emergency situations. A view was expressed that essential health services were needed in life threatening situations. However, the key barriers that the IDPs face in accessing quality health care such as economics, distance and culture cannot be avoided and constitute challenges.

i. Economic barriers

Those IDPs on low incomes often have difficulties with the cost of accessing services. This involves both difficulties with the payments necessary for health services, and the cost of travelling to access them. In addition, IDPs who are severely affected by the impact of complex emergencies are less able to work and generate income for themselves and their dependants.

The costs of health care in health facilities posed a very real challenge to IDPs whose economic resources were already severely constrained. The IDPs in Manado discussed several issues in relation to their experiences. As they stated:

> *"…we have to pay Rp 5,000 • for health services, and sometimes we have to pay Rp. 3,000 for a syringe for injection"* (Adult female, Mapanget).

> *"…yes we have to pay the costs for the health services and this is a great burden to us who have had bad experiences in our lives and lost our property and other things, we are poor (*Adult male, Mapanget*).*

• Rp. 3,000 = 15 pence and Rp 5,000 = 25 pence

Although the IDPs have to pay for family planning methods the use of the service is easy. As the one respondent commented:

> *"…to get family planning service offered by health facilities in this area was very easy for me, but I had to pay Rp. 25,000 = £2 for the contraceptive method and it is expensive for me"* (Adult female, Mapanget).

In addition, in the discussion the IDPs who reported illness were unlikely to have sufficient money for taking care of their health. The cost of the services and the cost of transportation made the IDPs, particularly the poor, averse to attending health services provided by the public sector. The respondents in Sampang commented:

> *"…we don't have enough money to get the health services and we have to pay the transportation to the health centre and purchase the drugs"* (Adult male, Robatal).

> *"…I went to the puskesmas to have a treatment…I had to buy a Rp. 5,000 for the ticket. I also heard that…if we want to have an injection we have to pay for the syringe…I don't know how much it costs and we don't have enough money to cover it" (*Adult female, Ketapang*).*

In both Manado and Sampang, low economic status among IDPs presents a major barrier to obtaining essential health services and appear to be a substantial contributor to health risks. Low IDP income in particular was associated with a decreased use of health services.

ii. Distance barrier

The distance between the temporary accommodation and health facilities particularly for those IDPs living in remote recipient areas is significant. They must travel in order to obtain health services.

In Manado, during the discussion the distance factor contributing to the utilisation of health facilities was raised by the respondents. In order to reach the *puskesmas*, the IDPs had to use local transport, which was not always available. As one commented:

> *"…the locations of health facilities are too far from our place and we need transportation to go there"* (Adult female, Mapanget).

In Sampang, those who lived in the woods in Robatal and Banyuates had to walk quite a distance to reach the health facilities. No transport was made available for them to reach the health facilities provided within those sub-districts. In these areas, the majority of IDPs have limited access to adequate health services due to living in a remote location. As one respondent commented:

> *"…we are living in a remote place and for us it is difficult to get access to health services. Yes, we have a regular health service from puskesmas who visit us every month, but when we have illness, the schedule of the mobile puskesmas is different. Illness doesn't recognise the time schedule of the puskesmas (laughter)"* (Adult male, Banyuates).

Distance is a barrier that prevents IDPs who lived in rural/remote places from accessing health services. The distance between the health facilities and temporary accommodation clearly influenced the access of the IDPs to the health facilities in both field areas, even though there was a mobile visiting *puskesmas*. This situation could contribute risks to IDPs' health especially in the case of an infant or child with an acute illness.

iii. Cultural barrier

Cultural attitudes toward suffering, such as beliefs that suffering is inevitable or that one's life span is predetermined, can cause people not to seek health care facilities. Cultural beliefs about the sources of illness and correspondingly appropriate forms of treatment can also be a barrier to accessing health services.

During the discussions in both field areas, some respondents expressed strong beliefs in terms of using health services. As the respondents commented:

> "*…we believe that an infant under six months old should never be injected"* (Adult female, Mapanget).

> *"… I went to the traditional healer to get the traditional drugs for my cold, because I believed the drugs from the traditional health will cure my diseases* (Adult female, Robatal).

The culture of the IDPs was highly influential in determining their use of the services, particularly as seen in the reluctance of women to deliver their babies in health facilities.

The traditional birth attendants are customarily female, often relatives and birth is seen as a natural process. As one respondent commented:

> *"…I preferred to deliver my baby in my house; it was more convenient because I felt comfortable compared to being in the puskesmas. I just felt uncomfortable about delivering in the puskesmas. I delivered my baby with the TBA's help and the delivery process was safe, the baby was fine"* (Adult female, Mapanget).

The above findings illustrate the problems and experiences of IDPs in Manado compared to those in Sampang District. Similar problems were faced by the IDPs in both areas, particularly in access to health services provided by the public health sector. A number of barriers faced by IDPs in seeking healthcare were identified, where economics, distance and cultural factors contributed to the barrier to health services.

IDPs perceptions of access to health services reveal that it is an overall continual problem for them. Distance from the temporary accommodation to the health facilities, coupled with inadequate and unaffordable transport make it problematic for the IDPs to reach the health facilities to obtain appropriate health services. Access to health services is one of the major determinants of the health and well being of IDPs. Access to quality and affordable health services depends on physical access to health facilities and on financial (economic) access to (affordable) health services.

Sub-theme 5.5.4 Satisfaction with Health Services

People have a tendency to be satisfied when their expectations of the health service they receive are fulfilled. Expectation are learnt from experiences (Carr *et al*, 2001). When the health service falls short of expectations they tend to be dissatisfied. In this research the definition of IDPs satisfaction was limited to the respondents' perceptions of service delivery, including communication with the health workers, while receiving health services in public health facilities.

In Manado, during the discussion, there was a complaint about the services provided by the health officers, particularly the drugs that the health facility gave to the IDPs.

Moreover, communication between IDPs and health workers was inadequate in terms of getting information provision. As the respondents commented:

> *"…when I went to the puskesmas to get treatment, I was treated by the nurse, who was very kind to me and skilled in terms of giving me advice and drugs, although the consultation only lasted less than 3 minutes* (Adult female, Mapanget).

> *"…when I visit the puskesmas to cure my disease, the drug that I received was similar to the drugs that my friend received, although we suffered from different disease symptoms* (Adult female, Mapanget).

> *"…I was not satisfied with treatment in the puskesmas. I needed more information about the illness from which I suffered so much" (*Adult female, Mapanget).

The experiences of IDPs during treatment in the health facilities showed that duration of consultation, type of drugs and health information are the main factors that contribute to satisfaction with the health services provided by the public health sector.

In Sampang some respondents commented that those who went to health facilities were satisfied with the service they received, although they complained that the appearance of the drugs that they received from *puskesmas* were the same in terms of shape, colour and composition for all their different symptoms. As a consequence they doubted the drugs' efficacy. As one respondent commented:

> *"…the drugs that I received were similar to one of my family's drugs, although we had different symptoms"* (Adult female, Ketapang)

Other respondents commented on the adequacy of the treatment that they had from health facilities, including poor communication with the health workers who gave them treatment. As they commented:

> *"…several times over 3 months I went to the puskesmas to have treatment for my illness, but I still feel unwell* (Adult male, Robatal*).*

> *"…I was not pleased with treatment of the health facility in this area because the nurse didn't mention what kind of disease I was suffering from and it was only less than 3 minutes the examination* (Adult male, Ketapang*)*

The satisfaction with health services varied according to the individual and the nature of the service offered. Overall, the respondents' complaints about health services were similar in both Sampang and Manado.

Theme 5.6 Other Issues Related to Health of IDPs

In this research additional issues that related to the health needs of IDPs during the period they lived in both field areas focused particularly on food security, security and social interaction with the local community.

Sub-theme 5.6.1 Food Security

A complex emergency is both a cause and an effect of food insecurity and this extends to the post complex emergency situation in the recipient areas, particularly in areas of low local food supply. A shortage of food and lack of variety can cause malnutrition and deficiency diseases. A healthy food supply for the IDPs is considered to be a determinant of health and this also prevails in the life of IDPs' in temporary accommodation areas.

The provision of food aid is a primary response of governments during complex emergencies and post-emergencies. In Manado some time before this research, food aid had been discontinued by the international agencies and NGOs. As one respondent commented:

> *"…when we first arrived in this area we received food, but there has been no food distribution from the government and World Food Programme (WFP) in the barracks since 2003* (Adult male, Mapanget*).*

However, before that the IDPs received food from the government and NGOs. As one respondent commented

> *"…at the beginning of settlement in the relocation area we got support from sources such as WFP and NGOs. The food consisted of rice, noodles, fish and canned meat as well as biscuits and milk" (*Adult female, Mapanget).

The quantity of food available to them during the period they had lived in the temporary accommodation area was adequate. As the one respondent commented:

> *"…we were eating three times a day and the meals were composed of rice and corn with variety provided by meat, fish, tofu and vegetables. Also we felt it was easy for us to get sufficient food because we had access to the local market"* (Adult male, Mapanget).

Although there was no longer a food supply from the government, international agencies or NGOs, in general the availability and accessibility of food in this relocation area was sufficient.

In Sampang, during the survey, it was apparent that in this district food security was not a concern for the IDPs. In the first and even in subsequent years of their time in this district, most of their food requirements were met by a combination of government and international assistance, but at the time of this survey the food aid programme had been discontinued. One respondent commented:

> *"…the first year we arrived in this area there was food distribution from the government and WFP in the barracks but in 2003 the service was terminated* (Adult female, Robatal*).*

Accessing food supplies did not seem to be a problem for the IDPs in both field areas. At the time of the survey their finances were in a relatively healthy state because they had received funding from the Indonesian government to either return to their homelands or to set up a small business in their recipient areas. This money was a 'one off' payment so when it was all spent there would be no more and those who had not managed to find secure employment could find themselves in a precarious situation regarding the necessities of life. This would be a potential threat to their health.

Sub-theme 5.6.2 Security and Social Interaction with Local Community

Security and social interaction are important because if these situations are unfavourable they could contribute to difficulty of access to health services. In Manado, this research found that the interaction between IDPs and local community was only "fair" because there was a conflict between young IDPs and local youth. As the respondent commented:

> *"…sometimes the young men have clashed, but in general we have a good relationship with the people here* (Elderly male, Mapanget).

Moreover, a dispute existed between the local community and the government about the land occupied by the IDPs in the brick house compound. As the respondent commented:

> *"…we heard… the local people complained to the local government about the land that the temporary accommodation were settled in… but we don't want to get involved because we are IDPs"* (Adult male, Mapanget).

In Sampang, the interaction between IDPs and the local community was also only "fair" since the local community felt that they were becoming less secure because of frequent disputes between young IDPs and the local young community. As one respondent commented

> *"…the security in this area is fine for us, but we worry because sometimes there has been fighting between young IDP men and the local young men block the road to the market and other public facilities"* (Young male, Banyuates).

In addition, there was competition for water distribution between the IDPs and the local community as one respondent said:

> *"…sometimes we have had frictions such as the matter of distribution of water through water pipes and tanks. The water supplies provided by NGOs were supposed to go to the IDPs, but unfortunately the water system went to the local community instead*" (Adult male, Robatal).

In both field areas, security conditions and the state of social interaction between IDPs and the local community influenced the health status of the IDPs. Access to health services by the IDPs may be hindered if there is tension, for example the host community may block access to the health facilities located in the recipient area.

From the analysis of qualitative data several factors have been identified as being significant in determining the health status of IDPs in both field areas. The information from direct observation and focus group discussion on the variables within the themes indicated not only the problems that had the potential to decrease the health status of the IDPs and increase their health needs but also the things that were working well. For example, accessing food in both field areas was easy and the living conditions and sanitation in Manado were such as to minimize the risk factors of diseases.

The following section presents the quantitative data gathered from a survey and statistical analysis.

Quantitative Data Analysis

In this research, quantitative data analysis presents and interprets the numerical data gathered from the survey in order to answer the research questions**.** Although the data are quantitative in the sense of being expressed numerically, a mistake was made in sample size calculation. As a result, tests of the significance of difference between groups may present false negatives. For this reason, a qualitative, descriptive approach is taken to the presentation of these data.

In Manado Municipality in Mapanget Sub-district, the survey selected 71 sample households. The respondents were the Heads of households (persons in charge of the household) or the person who was believed by household members to be in charge (the person/member of the family in temporary accommodation, for example the wife). Of the 71 respondents, 38 were male and 33 were female. Five of the women were widowed single parents. In Sampang District a similar survey of 116 households was conducted in several sub-districts; namely Kepatang, Banyuates and Robatal. Of the 116 respondents 108 were male and 8 were female.

Even though the status of the IDP groups in Manado and Sampang was similar, they were different in the determinant health factors expected to influence their health status. Health status of IDP respondents was assessed, particularly for the main diseases in the distribution of age in household members who were ill and deaths were recorded.

The statistical package, SPSS, was utilized in the analysis of data gathered from the survey to aid the researcher in its quantitative analysis, particularly in the descriptive analysis. The descriptive analysis of the data survey was as follows: 1) health status of the respondent (morbidity and mortality features); 2) the type of temporary accommodation and its allocation to households; 3) characteristic of household respondents; 4) essential health services (MCH, family planning, immunisation, nutrition, environmental health and basic medical treatment) offered by public health sectors.

Detailed findings and analysis will be explained in the following sections.

5.7 Health Status of Household Respondents

Health status of an individual, group or population is measured against accepted standards (Bowling, 2005). For this research it is a profile of health for a specific population, a specific geographical area and at the time of survey.

Since no single best measure or standard of health exists, it is necessary to examine a variety of indicators and/or factors that put individuals at increased risk of disease or premature death. According to Bowling (2005) health status problems are generally perceived in one of the following ways: 1) there is a feeling by an individual/group or community that there is too much of an adverse health condition; 2) community assessment reveals a problem.

In order to explore the perceived health problems of IDPs in both field areas the above approaches, particularly approach number one, were used for this research focused on morbidity and mortality during the period the IDPs lived in temporary accommodation. Disability was not focused on analysis of this research because during the survey no respondent report of disability in Manado and only little number in Sampang.

5.7.1 Morbidity Features

Morbidity in this research explored the disease patterns perceived by the IDPs themselves as symptoms in the month preceding the interview. In Manado municipality, of the 71 respondents 59% (n=42) mentioned that members of their family had been ill. 41% (n=29) said no one had been ill.

The study found the diseases or symptoms as perceived and reported by respondents included the common cold, fever and coughs, arthritis, gastritis, abdominal pain, muscle cramps, diarrhoea, skin diseases, foot swelling, headache and toothache, hernia, hypertension, kidney failure, low appetite and insomnia, malaria, muscle pain, urine retention and varicella.

Of the 42 respondents who reported disease, 15 household members had recovered. 27 respondents reported continuing illness, citing coughs, abdominal pain, arthritis, gastritis, migraine, hernia, hypertension, kidney failure and gouty arthritis.

In Sampang district, of the 116 respondents, 56% (n=65) mentioned that members of their family had been ill and 44% (n=51) said no one had been ill. The diseases or symptoms as perceived and reported by respondents included cough, abdominal pain, common cold, varicella, dermatitis, gastritis, headache, migraine hernia, hypertensive, influensa, kidney failure, malaria, myalgia, bone fractures, arthritis, kidney failure, urinary stones and paralysis.

In this survey in Sampang, of the 65 respondents whose family members suffered from disease, 60% (n=39) recovered. 40% (n=26) remained ill with bone fractures, urinary stones, kidney failure, headache, gastritis, and paralysis. This survey shows most of the household members who continued to be ill suffered from non-communicable diseases.

In the survey of these two areas, the most frequently reported symptoms included both acute and chronic conditions. This range of reported symptoms does not give a full sense of the effect of these problems on IDPs' during the period they lived in the temporary accommodation. However, it does provide a critical pointer towards the definition of health service delivery needs to be explored in this research.

In both field areas previous exposure to conflict affected the IDPs' health. This research found psychological stress caused by the complex emergencies still existed such as low symptoms of appetite, insomnia and headache. In addition, their extended stay in temporary accommodation contributed to the illness of the IDPs (discussed in section 5.9.7).

5.7.2 Causes of Death

This survey sought to determine the number and causes of IDP household members' deaths during the period of time that the IDPs lived in temporary accommodation in both field areas. In Manado, among 71 households, eight household members were reported

to have died. There were five adults, two children under 15 years old and one child under 5 years old.

This survey found that dating from the time they arrived, the cause and number of mortality among eight IDPs living in the temporary accommodation area was three malaria, one brain cancer, one stroke, one hypertension, one breast cancer and two 'don't know'. Thus verbal evidence from the households indicated that, apart from malaria, non-communicable diseases were the main cause of death. Malaria, as a communicable disease that can be prevented and treated, is still an important cause of death in the temporary accommodation area in Manado.

In Sampang, the survey recorded that 13 household members of the 116 respondents had died. Of the household members who died during the IDPs time in the area, eight were adults, one child under 15 years old, and three were children under 5 years old, including one infant. The causes and number of death was three 'fever', one pneumonia, one diarrhoea, one TB, one stroke, one 'stomach swelling', one stillbirth and three 'don't know'.

The impacts of post complex emergency among the IDPs, who lived in Sampang, particularly in the causes of death, were not prominent. This research found there were no characteristic causes of death among the IDPs in Sampang.

5.8 Type of Temporary Accommodation and Household Allocation

As mentioned previously, in Manado the respondents were living in two different types of temporary accommodation. Of the 71 household respondents; 21% (n=15) lived in the Kitawaya building and 79% (n=56) in the brick houses. This survey explored whether the incidence of illness was associated with living in these different types of temporary accommodation.

Table 5.1: Type of temporary accommodation and number of associated IDP illness in Manado Municipality

Type of Temporary Accommodation	Illness in household		Total
	Yes	No	
Kitawaya Building	8 (53%)	7 (47%)	15 (100%)
Brick Houses	34 (61%)	22 (39%)	56 (100%)
Total	**42 (59%)**	**29 (41%)**	**71 (100%)**

A slightly higher proportion of households who lived in brick houses (61%) reported illness, compared to those who lived in the Kitawaya building (53%) as shown in the Table 5.1.

In Sampang, the IDPs lived in the barracks and houses built on relatives land. Table 5.2 shows the distribution in temporary accommodation of the 116 respondents.

Table 5.2: Household allocation to accommodation by type of accommodation and sub-districts in Sampang District

Type of Temporary Accommodation	Sub-district			Total
	Ketapang	Banyuates	Robatal	
Barrack	10	12	10	32
Houses built in relatives' land	31	31	22	84
Total	**41**	**43**	**32**	**116**

More respondents lived in houses built on relatives land - 72.4% (n= 84) - than in barracks 27.6% (n=32). The survey investigated whether living in resettlements with overcrowding and poor sanitary facilities as in some barracks and houses built on relatives' land in Sampang District had actually increased susceptibility to disease.

Table 5.3: Type of temporary accommodation and number of associated IDP illness in Sampang District

Type of Temporary Accommodation	Illness in household		Total
	Yes	No	
Barracks	18 (56%)	14 (44%)	32 (100%)
Houses built on relatives' land	47 (56%)	37 (44%)	84 (100%)
Total	**65 (56%)**	**51 (44%)**	**116 (100%)**

This survey found, there were similar proportions of households that reported illness who lived in barracks (56%) and who lived in houses built on relative's land (56%) as shown in Table 5.3.

5.9 Characteristics of Household Respondents

A household is a domestic unit consisting of the members of a family who live together along with non-relatives such as friends or servants (Houghton, 2004). In this survey a household is defined as one or more people residing together in the temporary accommodation.

The characteristics of the household respondents in this survey were determined by the demographic information gathered from the survey - distribution of households by origin, ethnicity and religion; age and gender; structure and composition of households, education and occupation of the Head of the household. The reason for collecting some factors of demographic characteristics was to ascertain any association with health issues, particularly illness. Information on household-instigated relocations, where the respondents had previously lived and length of stay in the re-settlement area were also explored.

5.9.1 Distribution of Households by Origin, Ethnicity and Religion

The origin, ethnicity and religion of household members were significant factors in the demographic background of respondents. According to (UNOCHA, 2003) acceptance of IDPs in the recipient area tended to be based on shared associations of ethnicity, culture and history.

In some parts of Indonesia, ethnicity determines one's religion and everyday aspects of life. Ethnic backgrounds are important because they have implications in terms of cultural beliefs and whether or not the different health services available are appropriate in cultural terms to IDPs. In addition, problems may arise if different ethnic groups are forced to stay together in the same barracks. Not only do cultural practices and religious/denominational beliefs differ (IDPs often come from different islands) but old hostilities may find new expression in situations of close proximity.

The IDPs in Manado are Christian and came from different islands and sub-districts in Halmahera, Morotai and Ternate islands in North Maluku Province (Table 5.4) where there had been conflict. They were a slightly diverse society with different traditions and customs in their homeland. The traditions and customs of IDPs may have influenced health decisions, particularly in the choice of health services. For example, as mention in qualitative data analysis section, the displaced women who were pregnant were more comfortable using traditional birth attendants in support of their pregnancy, as they would have done in their homeland, than professional midwives or nurses.

Table 5.4: Origin of respondents resettled in Manado Municipality

Area of Origin	Number	Percent
Ternate	29	40
Halmahera	26	37
Morotai	16	23
Total	**71**	**100**

In Sampang, the IDPs came from a variety of areas in Sampit District in Central Kalimantan Province (Table 5.5), with the majority from Baamang followed by Mentawa Baru sub-district in Sampit district Central Kalimantan province.

Table 5.5: Origins of respondents resettled in Sampang District

Area of Origin	Frequency	Percent
Baamang Sampit	49	42.1
Bajarum Kota Besar Sampit	3	2.6
Bejarum Sampit	3	2.6
Kapuas Sampit	11	9.5
Kota Besi Sampit	5	4.3
Kota Kamar Duapuluh, Sampit	3	2.6
Kota Sampit	10	8.7
Mentawa Baru Ketapang Sampit	23	19.8
Mentawa Hulu, Kuala Sampit	2	1.7
Samuda Sampit	6	5.2
Sungai Serambut Besar, Sampit	1	0.9
Total	**116**	**100**

Ethnicity was a key factor that contributed to the IDP's choice to come to the district after their escape from the riots in Central Kalimantan Province. The respondents were ethnic Madurese who lived on Kalimantan Island and had been born there.

The people of this district are Madurese and Moslem. The IDPs who arrived there were also Madurese and Moslem.

5.9.2 Distribution of Age and Gender

Age and gender are important variables of the demographic characteristics of the IDPs and were the primary basis for assessing morbidity and mortality as referred to in the previous section on the health status of IDPs. An individual's age also determined whether they were or were not still able to support their family in providing basic needs for their family. In this research, an individual's age often determines whether they are or are not still productive in supporting the economy of the family.

Gender is important because male and female have different health needs. This demographic information on both age and gender were used to link the health status of the various members of the households.

In Manado, this research found the mean age of the respondents was 35.6 (SD +/- 11.6) years (range 16-69 years) as shown in Table 5.6. The majority of the respondents were adults of productive age. There were no respondents <16 years old, because during the survey there were no child headed households and every household respondent presented the person that they believed could give the correct information.

Table 5.6: Distribution of age and gender of respondents in Manado Municipality

Age group (years)	Frequency of respondents	Percent age distribution	Male	Female
16-29	17	23.9	4	13
30-39	28	39.4	20	8
40-49	16	22.5	7	9
50-59	7	9.9	4	3
60+	3	4.2	3	-
Total	**71**	**100**	**38**	**33**

The 71 household respondents reported on the experiences of 298 household members, including themselves.

Table 5.7: Age and gender of household members in Manado Municipality

Age distribution of household members	Male	Female	Total
Elderly (> 65 years old)	5	7	12
Adults (16 – 64 years old)	77	81	158
Children 6 – 15 years old	51	42	93
Children 1 - 5 years old	14	7	21
Infants	5	9	14
Total	**152**	**146**	**298**

There was slightly higher proportion of female adults than males and a higher proportion of male children aged 6 – 15 years (Table 5.7). The large number of children was an indication of the higher fertility rate of the population before they arrived at the relocation areas. In this survey the demographic shape of some of the households had changed because the men were working in other places.

In this municipality the incidence rate of illness was taken from adults because the the frequency was sufficient for calculation for rate of illness. The rate of illness of adults was 113, 92 per 1,000 population.

In Sampang, the 116 respondents reported on 565 household members, including themselves. The mean age of the respondents was 38.5 (SD +/- 12.5) years (range 19-78 years) as shown in Table 5.8**.**

Table 5.8: Distribution of age and gender of respondents in Sampang District

Age group (years)	Frequency of respondents	Percent age distribution	Male	Female
16-29	25	21.6	20	5
30-39	45	38.8	35	10
40-49	22	19	20	2
50-59	12	10.3	8	4
60-69	5	4.3	4	1
70+	7	6	6	1
Total	**116**	**100**	**93**	**23**

Table 5.9 sets out the age distribution of household members of respondents in Sampang district.

Table 5.9: Distribution of age and gender of household members in Sampang District

Age distribution of household members	Male	Female	Total
Elderly (> 65 years old)	8	12	20
Adults (16 – 64 years old)	141	153	294
Children 6 – 15 years old	65	65	130
Children 1 - 5 years old	47	57	104
Infants	9	8	17
Total	**270**	**295**	**565**

As shown in the Table 5.9, the number of female household members was higher than male, particularly in children in the 1 – 5 years age range and adults and also elderly. The numbers of male and female children aged 6 – 15 years were equal. The higher proportion of female adults in this sample was because some of the male adults had died in the conflict and others were working out of the district.

In this district the rate of illness was taken from adults and children 1 – 5 years old. The other age groups were not taken because the number of illnesses in them was too small. The adults were 112.24 and children 1 – 5 years old were 173.07 per 1,000 population. The rate of illness was particularly high among the children 1 – 5 years old, followed by the adults.

5.9.3 Structure, Composition and Size of Households

Structure and composition of households are important because of their potential for resistance to or rejection of the health services, for example the Head of a household's decisions on priorities regarding food or medical care could be dominant. Household size affects the IDPs health status in terms of shared consumption of food and water. Limited living space has to be shared by household members and can lead to an increase in transmission of communicable diseases.

In Manado, household members were seen in this survey as belonging to either: a nuclear family (husband and/or wife with/without unmarried children); an extended family (husband and/or wife with married and/or unmarried children plus husband or wife's parents and/or other close relatives) or were non-related individuals (a single person household or a person residing with non-related persons). In this survey the composition, referring to the members of respondent's household with regard to the elderly, adults, children 6-15 years, children 1-5 years and children under 1 year, was explored.

Table 5.10: Type of household structure and number of IDP household members in Manado Municipality

Size of Household (all members)	Type of Household Structure			Total
	Nuclear	Extended	Non-relatives	
2 – 3 persons	24	1	0	25
4 – 5 persons	23	8	7	38
6 - 7 persons	0	6	2	8
Total	**47**	**15**	**9**	**71**

Household sizes were wide ranging, from a low of two persons per household to a high of seven (Table 5.10). The majority of the 71 households contained between two and five persons. While the structure and composition of households in this area was dominated by the nuclear family, some of the household structures were different because non-relatives were living with them in the temporary accommodation. The survey analysed the relationship between the size of the respondents' household and reported illness.

Table 5.11: Incidence of illness related to household size in Manado Municipality

Number of Household Members	Illness in household		Total
	Yes	No	
2 – 3 members	15 (60%)	10 (40%)	25 (100%)
4 – 5 members	21 (55%)	17 (45%)	38 (100%)
6 – 7 members	6 (75%)	2 (25%)	8 (100%)
Total	**42 (59%)**	**29 (41%)**	**71 (100%)**

The table above shows that in Manado Municipality the incidence of illness in a household tended to increase with the number of household members.

In Sampang, household structure varied considerably from one sub-district to another. Where households had a large number of members, there was generally overcrowding; this was usually associated with unfavourable health conditions, particularly for those

IDPs who lived in small rooms in the temporary accommodation. Household structure is not only related to economic conditions, but can also have economic consequences of its own that impact on the health status of the household members.

In Sampang district the lowest number of persons in a household was two persons and the highest was between eight to twelve persons as shown in Table 5.12.

Table 5.12: Type of household structure and number of IDP household members in Sampang District

Size of household (all members)	Type of household structure			Total
	Nuclear	Extended	Non-relatives	
2 - 4 persons	44	4	0	48
5 - 7 persons	39	12	4	49
8 – 12 persons	5	6	2	13
Total	**88**	**22**	**6**	**116**

The characteristics of the structure and composition of households in this area were dominated by the nuclear family. There were also extended households where some of the household members were IDPs' relatives (such as son/daughter in law, cousin, or nephew of the Head of the household). Although there was wide variation over the sample in the size of households (from a low of two persons to a high of twelve persons) the most frequent household size consisted of 5 - 7 persons (Table 5.12). The analysis investigated the relationship between the size of the respondent's household and reported illness as showed in the table below.

Table 5.13: Incidence of illness related to household size in Sampang District

Number of household members	Illness in the household		Total
	Yes	No	
2 – 4 persons	29 (52%)	27 (48%)	58 (100%)
5 – 7 persons	29 (57%)	22 (43%)	51 (100%
8 – 12 persons	7 (78%)	2 (22%)	9 (100%)
Total	**65 (56%)**	**51 (44%)**	**116 (100%)**

The table above shows that in Sampang District the incidence of illness in a household tended to increase with the number of household members.

5.9.4 Educational Attainment

Education can play a critical role in health development, particularly in improving and maintaining health. In this research the educational attainment of IDPs was found to foster health and a potentially more stable population in post complex emergencies.

In Manado, the survey revealed that 38% (n=27) of the IDP respondents had advanced at least to Junior High School level. 34% (n=24) had attended Primary School and 28% (n=20) had attended Senior High School.

Table 5.14: Level of education background of Head of household related to reported illness in the households in Manado

Level of Education	Illness in Household		Total
	Yes	No	
Primary School	11 (46%)	13 (54%)	24 (100%)
Junior High School	17 (63%)	10 (37%)	27 (100%)
Senior High School	14 (70%)	6 (30%)	20 (100%)
Total	**42 (59%)**	**29 (41%)**	**71 (100%)**

Heads of households who had attained Senior High School reported more illness (70%) than those who ended their schooling at Primary School level (46%) and Junior School level (63%).

In Sampang, the survey revealed that 46% (n=53) of the IDP respondents had advanced at least to Primary School level followed by 41% (n=48) who did not attend school and 13% (n=15) who attended Junior High School.

Table 5.15: Level of education background of Head of household related to reported illness in the households in Sampang

Level of Education	Illness in Household		Total
	Yes	No	
No Schooling	28 (58.3%)	20 (41.7%)	48 (100%)
Primary School	30 (56.6%)	23 (43.4%)	53 (100%)
Junior High School	7 (46.7%)	8 (53.3%)	15 (100%)
Total	**65 (56%)**	**51 (44%)**	**116 (100%)**

There was a slightly higher trend in the proportion of Head of household members who had never attended school (58.3%) or who attended Primary School (57%) reporting illness compared with those who attended Junior High School (47%).

The survey suggests that the respondents who lived in temporary accommodation in Sampang district had a similar chance of becoming ill irrespective of the educational background of the household head - there is only a slightly negative relationship beween education and illness suggested.

5.9.5 Occupation of Respondents

The assessment of the occupational background of IDPs was intended to explore income generation and provision of livelihood. As stated in chapter three, this is because health status and income have been seen to be correlated. In Manado, employment is related to the sustainability of a household's economy and the household's income is a determining factor of health. The low per capita income of the IDPs is a risk factor for low health status. Only 40% (n=28) of the IDPs in this municipality were employed, 21% (n=15) not employed and 39% (n=28) had an uncertain job.

The survey indicated that the IDPs had taken on various kinds of informal work. A small proportion indicated they continued to pursue the livelihood that they had traditionally followed such as farming and fishing. The source of income generation has a bearing on the socio-economic status of the IDPs during their stay in the relocation area. Various occupations were identified during interviews in Manado (Table 5.16).

Table 5.16: Occupations of Heads of IDP households in Manado Municipality

Type of Occupation	n	Percent
No job	15	21.1
Uncertain job[•]	28	39.4
Skilled labour	17	23.9
Farmers	5	7.0
Fishermen	3	4.2
Government	3	4.2
Total	**71**	**100**

Table 5.17: Association between employment status and illness in IDPs in Manado Municipality

Occupation	Illness in Household		Total
	Yes	No	
Yes	17 (61%)	11 (39%)	28 (100%)
No	7 (47%)	8 (53%)	15 (100%)
Uncertain	18 (64%)	10 (38%)	28 (100%)
Total	**42 (60%)**	**29 (40%)**	**71 (100%)**

Table 5.17 depicts occupational status and frequency of reported illness in household members. Respondents with uncertain occupations had more illness than those who had a job and those who were unemployed.

In Sampang, respondents had a variety of jobs but 22.4% (n=54) were employed, 22% (n=26) not employed and 31% (n=36) had an uncertain job. During the interviews, this survey identified the various occupations of the respondents (Table 5.18).

[•] In this survey 'uncertain job' refers to a variety of informal work such as broker, courier and clothes washer; under this category, some had begun small scale businesses such as small storekeeping near the temporary accommodation.

Table 5.18: The occupations of Heads of households in Sampang District

Occupation of Respondents	n	Percent
No job	26	22.4
Uncertain job	36	31.0
Skilled Labour	27	23.3
Farmers	25	21.6
Fishermen	2	1.7
Total	**116**	**100**

Table 5.19 shows the employment status and frequency of reported illness in IDPs in Sampang District.

Table 5.19: Association between employment status and illness in IDPs in Sampang District

Employed	Illness in Household		Total
	Yes	No	
Yes	33 (61%)	21 (39%)	54 (100%)
No job	13 (50%)	13 (50%)	26 (100%)
Uncertain	19 (53%)	17 (47%)	36 (100%)
Total	**65 (56%)**	**51 (44%)**	**116 (100%)**

Respondents in this district with jobs had more illness than those without or those with uncertain jobs, unlike the situation in Manado.

5.9.6 The Number of Household-instigated Relocations

Being displaced, often on more than one occasion, and having a low standard of living could potentially have a negative impact on the health of the IDPs, because of increased susceptibility to diseases or by wider exposure to diseases. In Manado the temporary accommodation, prior to those encountered during the 2004 survey, was in former office buildings belonging to the local government, warehouses and community centres and were located in several areas in Manado and Bitung Municipalities as well as other districts in North Sulawesi Province.

All the IDP respondents had been relocated more than once; 82% (n=58) were displaced twice and 18% (n=13) three times.

Table 5.20: Number of moves related to illness in IDPs in Manado Municipality

Number of Moves	Illness in Household		Total
	Yes	No	
Twice	35 (60%)	23 (40%)	58 (100%)
Three times	7 (54%)	6 (46%)	13 (100%)
Total	**42 (59%)**	**29(41%)**	**71 (100%)**

IDPs who moved twice were proportionately more likely to become ill than those who moved three times (Table 5.20).

In Sampang District, 59% (n=68) respondents had been relocated once and 41% (n=48) relocated two times. Table 5.21 below depicts how many times the IDPs moved either in or outside Sampang District in relation to occurrence of illness.

Table 5.21: Number of moves related to illness in IDP households in Sampang District

Number of Moves	Illness in Household		Total
	Yes	No	
Once	43 (63.2%)	25 (36.8%)	68 (100%)
Twice	22 (45.8%)	26 (54.2%)	48 (100%)
Total	**65 (56%)**	**51 (44%)**	**116 (100%)**

IDPs who moved only once were proportionately more likely to develop illness than those who moved twice.

5.9.7 Length of Stay

The length of stay in exile of IDPs is highly dynamic and changes continuously throughout the recipient areas. However, there was an argument that the longer the IDPs stayed in recipient areas, the less they were interested in their homeland. The concern of this research is the significant influence of length of stay on the health status of the IDPs. The length of stay of IDPs in temporary accommodation may be used in assessing the need for health services provided by public health institutions particularly in the recipient IDP areas.

In Manado, the IDPs in the relocation area of Mapanget Sub-district had arrived at various times, and came from other camps in Manado and Bitung Municipalities or other places in North Sulawesi. This occurred over the period from April 2001 to April 2003. One of the terms of resettlement set by the local government in this area was the requirement to return to their homeland if the situation there became settled. At the time of the survey in Manado 79% of IDPs, largely those in brick houses, had stayed for 2 - 3 years and 21% had stayed for more than 4 years in the Kitawaya Building (Table 5.22).

Table 5.22: Length of stay and illness in the IDP households in Manado Municipality

Length of Stay	Illness in Household		Total
	Yes	No	
2 – 3 years	34 (60.7%)	22 (39.3%)	56 (100%)
> 4 years	8 (53.3%)	21 (46.7%)	15 (100%)
Total	**42 (62%)**	**29 (38%)**	**71(100%)**

Thus, IDPs who stayed only two or three years were more likely to become ill than those who stayed more than four years.

In Sampang, shortly after the riots in Central Kalimantan Province, the Madurese fled to this district. They arrived at various times between January 2001 and June 2003, the period between January and March 2001 being the peak arrival period. At the time of this survey (May - June 2004), 76% of IDPs had been living in Sampang District for more than 3 years and 24% between 2 and 3 years. A small number of IDPs came later to Sampang having fled at the time of the conflict to other safe places in Indonesia. They then in the following years decided to join their family and friends in the barracks or temporary houses of Sampang district.

It was found that 64% of IDPs who had stayed 3 years or more reported illness, compared with 32% of IDPs who had stayed for only two-three years (Table 5.23).

Table 5.23: Length of stay and illness in IDP households in Sampang District

Length of Stay	Illness in household		Total
	Yes	No	
2- 3 years	9 (32%)	19 (68%)	28 (100%)
> 3 years	56 (64%)	32 (36%)	88 (100%)
Total	**65 (56%)**	**51 (44%)**	**116 (100%)**

5.10 Essential Health Services Offered by the Public Sector

The essential health programmes and services provided by the public sector in terms of how the IDPs accessed and met their health needs through *puskesmas* was investigated. The focus of this study was on the health programmes and services relating to maternal and child health care, family planning, immunisation for children, nutrition, and environmental health. Basic medical treatment was also explored in some detail.

5.10.1 Maternal and Child Health Care

The Indonesian maternal health programme recommends that pregnant women have at least four antenatal care visits during pregnancy according to the following schedule: one visit in the first trimester, one visit in the second trimester, and two visits in the third trimester (BPS, 2003). This recommendation is important in helping to ensure that women and the newborn survive pregnancy and childbirth and to make sure that the risk factors during pregnancy, preparation for birth and delivery processes are minimised.

In this survey, the respondents for maternal health care were women who were pregnant during their stay in temporary accommodation and who delivered their babies there. There was also value in identifying IDP women who do not utilize such services. Information on the use of services is important and useful in making recommendations for improving health programmes and services in Maternal and Child Health (MCH) care.

In Manado, the survey found that of the 71 respondents, 21 household members had been pregnant and had already delivered during the period of their stay in the temporary accommodation. In these 21 respondent households, 19 went to the health facilities for ante natal care and the two respondents never had antenatal care (ANC).

In this survey, significant variations were found in the control of place and times to have ANC. 17 of pregnant women went to a *Puskesmas*, two went to a health post and two had not looked for antenatal care (Table 5.24). Most of the women had a check-up in the *Puskesmas*, with an average frequency of two visits.

Table 5.24: Places and number of IDP visits for ANC in Manado Municipality

Places for ANC	Frequency of ANC				Total
	Nil	Once	Twice	Third	
Puskesmas	0	2	12	3	17 (81%)
Health Post	0	0	1	1	2 (9.5%)
Doctor/Nurse/Midwife Clinic	0	0	0	0	0 (0%)
TBA	0	0	0	0	0 (0%)
Not at all	2	0	0	0	2 (9.5%)
Total	**2**	**2**	**13**	**4**	**21**

This finding indicated that during pregnancy most of the women in the sample used the health facilities to check on their pregnancy.

During the IDP's stay in Mapanget Sub-district, 21 babies were delivered without complications. Home was the most frequent place for delivery (n= 8), while health facilities accounted for (n=2) and other for (n=11).

The person who assists the delivery is also important during the delivery phase; skilled health workers such as doctors and midwives are required in order to minimise the obstetrical complications such as bleeding, eclampsia or sepsis during the delivery process. Delivery services in this survey were categorised according to the person assisting during the delivery process. One woman's delivery was helped by a doctor, two were assisted by midwives and eighteen were helped by TBAs. Apart from the formal health system, TBAs were commonly used by women for home deliveries.

For ANC most women had their pregnancies supported in health facilities (except the two respondents previously mentioned), but most delivered their babies with the help of TBAs. One of the possible reasons for this could be the emotional relationship between the pregnant women and their families with the TBAs who were also IDPs. In the interviews, according to the pregnant women there were no emergencies [•] during their deliveries.

The survey also considered whether the pregnant women had to pay for the delivery process during their stay in the temporary resettlement area. It was found that 17 of the 21 women did not pay but gave money gifts as rewards to the TBAs. Two respondents paid the midwife according to their ability to pay and two others were not required to pay because they were supported by NGOs.

Postnatal care is important because the mother's health is regarded as being as important as that of the newborn. To detect any postnatal problems mothers are examined at health facilities to check that the uterus has returned to its original position and they are also offered information on breast feeding (personal experience). Usually in Indonesia, the health worker in the birth clinic, *puskesmas* or hospital will also offer mothers counselling on available contraception/family planning options (personal experience). In this survey information on postnatal care was collected from women who gave birth in health facilities or elsewhere.

Of 21 pregnant women who were delivered, twelve attended the postnatal care at puskesmas, five attended posyandus and four did not attend.

[•]It was ascertained from the questionnaire and interviews with women who delivered at home that they considered they had had no complications. None of these women had had to be taken to hospital because of difficulties in their deliveries. There were no official figures on IDP complications during delivery, nor any reports of consequential complications.

The survey findings show that the MCH programme provided by the public health sector had not improved the awareness/motivation of pregnant women had no result in encouraging use of the health facilities for delivery. The small number of pregnant women using the health facilities for labour was also influenced by the low level of economic status of the IDPs, exacerbated by the distance from the temporary accommodation area. Moreover, as previously mentioned, there was a strong belief by the pregnant women and their families that the TBA was best for assisting labour.

In Sampang, in line with the programme to improve maternal health and to make maternal health care services more accessible in remote places, village delivery posts (*polindes*) had been established, in addition to *puskesmas* in every sub-district. A village delivery post is a simple maternity post attended by a midwife (usually a young midwife) in a rural place. The purpose is to reach and serve pregnant women in remote areas.
This survey found that, of 116 respondents, 32 household members became pregnant during their stay in Sampang District. At the time of the survey 29 had delivered and 3 were still pregnant. Of the 32 respondents who became pregnant four did not attend ANC (Table 5.25).

Table 5.25: Sources and number of IDP visits for ANC in Sampang District

Places	Frequency of attendance for ANC				Total
	Nil	Once	Twice	Third	
Puskesmas	0	6	4	0	10 (31%)
Health Posts/*Posyandu*	0	0	1	3	4 (12.5%)
Doctor/Nurses/Midwife Clinic	0	1	9	0	10 (31%
Village delivery post/*Polindes*	0	0	0	0	0 (0%)
TBA	0	3	1	0	4 (12.5)
Not at all	4	0	0	0	4 (12.5)
Total	**4**	**10**	**15**	**3**	**32 (100%)**

Significant variations were found in the places for ANC and the number of visits. Of the 28 pregnant women who had ANC, most attended only once or twice. This indicates that, in terms of Indonesian's maternal health programme which recommends at least four antenatal care visits during pregnancy, coverage of ANC for pregnant women IDPs was inadequate.

90% of pregnant women were delivered in the temporary accommodation and 10% in health facilities. In this district poverty was the main contributory factor, worsened by the distance to health care facilities and costs for both delivery and transportation.
In this survey, the respondents were asked who the attending assistant was during the delivery process.

Table 5.26: Delivery assistants for pregnant IDP women in Sampang District

Sub-district	Delivery Assistants			Total
	Doctor	Midwife	TBA	
Ketapang	0	6	2	8
Banyuates	1	3	8	12
Robatal	2	3	4	9
Total	**3 (10%)**	**12 (41%)**	**14 (49%)**	**29 (100%)**

Table 5.26 above shows who assisted the 29 pregnant women who delivered in Sampang District. 49% were helped by TBAs, 41% by a midwife and 10% by a doctor.

In the delivery process, assistance during delivery is important because it determines the risk for the mother and baby. TBAs had a very strong role in delivery assistance for the IDP pregnant women in this area. The doctor who gave assistance at the 3 deliveries was in the district hospital, because two respondents had been referred to the hospital from the *puskesmas* and one respondent elected to deliver in hospital.
The survey found no complications or difficulties interfered with the process of these deliveries.

Of 29 pregnant women who were delivered, two attended the post natal care at *puskesmas*, two attended *posyandu*, eight other facilities (private doctor and midwife clinics), and seventeen did not attend.

The survey asked whether the pregnant women had to pay for the delivery process. It was found that 82% (n=24) out of 29 respondents had to pay for aides (doctor, midwife or TBA) and, according to them, the money came from the family budget. 17% (n= 5) of those who did not pay were delivered and helped by a TBA who was usually a relative.

In the two field areas, women's use of ANC, delivery and PNC from health facilities and professionals was examined in relation to their understanding of the risks in pregnancy, delivery and post delivery. For similar reasons, findings showed that the MCH programme to IDPs, as provided by the public health sector, had not resulted in significan use of facility based delivery. As in Manado, in Sampang District there was strong support for the use of TBAs for social and financial reasons, where they were favoured by the pregnant women to help in their delivery process.

5.10.2 Family Planning

Family planning programmes in Indonesia have been highly successful over the past 20 years through health facilities in providing women in the sub-districts with desired access to contraceptive services and helping to reduce fertility rates. In planning and providing the methods, either for the host community or IDPs, the *puskesmas* and hospital collaborated with the Local Bureau of Family Planning. The bureau provided the supplies (contraceptive methods), and the *puskesmas* and hospital had the technically skilled persons. Family planning programmes are also desirable because they are associated with a range of other benefits, most notably improvements in women's and children's health. In this research the access of IDPs to family programmes was highlighted.

In Manado, it was available to the entire municipal community with the intention of promoting sexual health and well-being and reducing unintended pregnancies (Dinkes

Manado, 2003). In this survey, of the 71 respondents 62% (n=44) of respondents were using contraceptives, while 38% (n=27) did not. Of the last group, the husbands of the female IDPs not using contraception were working in other areas, while some women had reached the menopause.

In Sampang, the family planning programmes available were reproductive health care, birth control, sexual transmitted disease prevention, out-reach and education services (Dinkes Sampang, 2003). These services, as part of the national programme, were also available to the IDPs who stayed in the temporary accommodation. Of the 116 respondents 49% (n=57) were using contraceptive methods and 51% (n=59) were not. As in Manado, in Sampang the husbands of the female IDPs not using contraception were working in other areas, while some women had reached the menopause.

In general, in both the field research areas the IDPs could access family planning programmes through health facilities available in the municipality or district. They had to pay for the contraceptive methods and services, as mentioned in the qualitative section.

5.10.3 Immunisation for Infants and Children

Immunisation programmes are important tools available for preventing disease. This was because some diseases are far more serious or common among infants. For example, infants under 6 months of age are at highest risk of serious complications of pertussis.

In order to allow access to immunisation services the government, through the Ministry of Health, had designed an infant health card. The purpose of the card was to record growth, nutritional status and immunisation. The card had to be brought to the health facilities either in *puskesmas* or Health Posts to receive the services. Although it was important that cards be kept by the mothers to enable them to monitor their children's growth and to keep a record of immunisation schedules, the type and date of vaccination are also recorded in a registration book maintained by the nurses or field vaccinators from *puskesmas*.

The survey of immunisation in this research focused on infants born in temporary accommodation. At the time of the survey in Manado, respondent families had 14 infants in the IDP households, 71% (n=10) could produce an infant health card while 29% (n=4) were unable to show the card or did not have one. However, according to the respondents their infants had received immunisation on several occasions.

In Sampang, in the survey of the 29 children who were born to the IDPs living in this district, 65% (n=17) could produce an infant health card. 35% (n=12) claimed they had lost the card but still took their babies to the health facilities for immunisation and weighing.

In seeking evidence of vaccination, the twelve infants with no health card were examined for immunisation scars. Ten infants were found to have a scar on either the left or right arms. Two infants had no scar indicating that they had probably not been immunised.

5.10.4 Nutrition

In this survey, of the 71 respondents in Manado, 70 said that the quantity of food available to them during the period they had lived in the temporary resettlement area was adequate and they could buy it in the local market.

In Sampang there had been a food programme provided by donor agencies and NGOs; of the 116 respondents, 115 stated that at the time of the survey the quantity of food was sufficient and could be obtained in the local market. One respondent stated that finding food was difficult, because they did not have enough money.

In both field areas, according to the respondents who had infants and children under 5 years old, a nutrition programme particularly for infants and children under 5 years old could be accessed through the *puskesmas*. This removed any nutritional problems for infants and children under 5 years old. However, as stated in section 5.6.1, the discontinuation of the food programme provided by donor agencies and NGOs to the IDPs late in 2003 created problems for a few IDPs.

5.10.5 Environmental Health

In these areas, environmental health programmes focused on water supply and sanitation. A number of health problems are related to inadequate water supplies and poor sanitation. The most significant threats are diarrhoeal diseases and infectious diseases transmitted by the faeco-oral route. Other water and sanitation related diseases include those carried by vectors associated with solid waste and water.

In this survey sanitation related to illness was explored only in Sampang, because in Manado all respondents used only toilets for defecation. However, in Sampang the IDPs defecated in two different places.

Table 5.27: Place of defecation versus prevalence of illness in Sampang District

Place for Defecation	Illness in Household		Total
	Yes	No	
Toilet	16 (53%)	14 (47%)	30 (100%)
Yard	49 (57%)	37 (43%)	86 (100%)
Total	**65 (56%)**	**51(44%)**	**116 (100%)**

A slighty higher proportion of household members who defecated in the yard (57%) reported illness, than those who defecated in the toilet (53%) as shown in the Table 5.27 above.

5.10.6 Basic Medical Treatment

In Manado, the variety of basic medical treatments available at the two *puskesmas* in Mapanget included treatment of common infections and minor surgery. The services were provided by doctors and nurses for outpatients only.

Of the 42 respondents' household members who had suffered from illness, 83% (n=35) received treatment from health facilities and 17% (n=7) did not use health facilities. Of the 35 respondents that received treatment 37% indicated adequate recovery (mainly from communicable diseases), while 63% indicated that they continued to be ill (mainly from non-communicable diseases).

In Sampang similar basic medical treatments were offered by the puskesmas.
Of the 65 respondents' household members who suffered from illness 77% (n=50) had received treatment at the three health facilities; 23% (n=15) did not use health facilities. Of 50 respondents who used health facilities and had basic medical treatment 58% felt that they had recovered adequately (mainly from communicable diseases) and 42% indicated that they remained ill (mainly with non-communicable diseases).

In both field areas, although the basic health treatment service was not for the IDPs exclusive use, the effectiveness of basic health treatment for their diseases was adequate for most of the communicable diseases. Problems were faced by IDPs when the diagnosis was of non-communicable disease.

Conclusion

This chapter has described separately the qualitative and quantitative data regarding a) the health status of IDPs in the two field research sites; b) the general situation of the resettlement area that affected the IDPs' health; c) determining factors that influenced current health status of the IDPs; d) access to and utilisation of health programmes and services provided by the public sector for the IDPs who arrived from North Maluku Province in Manado Municipality, North Sulawesi, and also those who arrived in Sampang District, East Java Province from Central Kalimantan province.
The chapter also outlined the essential health programmes that were provided by the receiving Municipal and District health authorities for the fulfilment of the IDPs' health needs and how the IDPs obtained the services.

The key challenges identified by the respondents concerning their health status, their access to and utilisation of health services in Manado Municipality and Sampang District included:

- the size of households in the barracks and houses built on relatives' land;
- lack of awareness regarding personal care of their health;
- the environmental health situation of their living area particularly in Sampang

- the existing diseases (communicable and non-communicable disease) and mental illnesses which had the potential to cause disability and death.
- poor communication with health workers during treatment
- the fees for health services and the distance to the health facilities diminishing their utilisation of the health facilities.
- security and social interaction with the local population

The essential health programmes provided by the public sector and offered to the IDPs were inadequate mainly due to cost and distance, particularly for those who lived in remote forest areas.

The following chapter explores the health system that existed in Manado Municipality and Sampang District in response to the health needs of IDPs and on the general effects of the health decentralisation policy.

Chapter Six

The Health System, and its Response to the Health Needs of IDPs and Health Decentralisation in Manado Municipality and Sampang District

Introduction

This chapter is based on findings from semi-structured interviews with the Heads of Manado Municipality Health Office (MHO) and Sampang District Health Office (DHO) and the Heads of two selected puskesmas in Manado and six puskesmas in Sampang. It includes analysis of related documents and observations. This chapter will answer the second research question as listed in the introductory chapter: *what are the problems experienced by services in seeking to meet these needs?* Several sub-questions are subsumed in this question and are related to the municipal and district health systems, the administrative and service levels in the provision of health services during the arrival period and extended stay of the IDPs and the general effects health decentralisation policy; and the impact on the capacity of these systems to respond.

The sub-questions are: did the arrival and extended stay of the IDPs affect the existing health systems in this district? Did the health decentralisation policy facilitate the development of health programmes and service provision, or did it create additional challenges?

The conflicts in Indonesia had impacted on the two field areas through the arrival of IDPs. In Manado, their arrival in December 1999 – January 2000 from North Maluku province expanded the responsibilities of Manado MHO, which had to set up health programmes and provide services for the IDPs who were living in temporary accommodation. Although some IDPs eventually returned to their home islands, many remained in Manado municipality. As a consequence the MHO had to continue to provide health programmes and services for them, creating challenges for the health systems that could not be avoided by the health authority.

A similar situation was created in Sampang District with the arrival of IDPs in February-March 2001 from Central Kalimantan Province. Although the central and local governments and NGOs encouraged them to return to their homeland, many people decided to stay in the district for an indeterminate period. As this district is the poorest in East Java province, this raised a number of additional challenges for the DHO, relating to health for IDPs.

Coinciding with the IDP crisis, in 2001 the MHO in Manado and the DHO in Sampang commenced implementation of the health decentralisation policy. Public health responsibilities were gradually transferred from central level to the municipal and district health authorities. As a result, the MHO and DHO were granted the authority and responsibility for development and provision of health programmes and services based on specific local needs.

Because of the health decentralisation policy, the health systems in Manado Municipality and Sampang District were undergoing change, in terms of the roles and functions of the M/DHO. Prior to decentralisation the functions of the M/DHO were limited to technical aspects of health matters. All other M/DHOs in Indonesia were undergoing similar changes. Since the decentralisation policy the MHO in Manado and the DHO in Sampang had become key players and authorities in the development of health programmes, implementing health policies and providing health services for their community.

In this chapter, close attention has been paid to those changes in the organisational process of the M/DHO that focused on administrative and service levels. The themes were developed and focused on the following aspects: the period of the arrival of IDPs; the challenges for both recipient areas in relation to providing health programmes and services to the IDPs; the impact of health decentralisation policy on local health systems; coordination within sectors related to health; the capacity of health resources in selected *puskesmas*; and the political situation in Manado Municipality and Sampang District.

Theme 6.1: The Period of the Arrival of the IDPs

1999 – 2001 saw the arrival of a large number of IDPs in both recipient areas. The situation affected the local health systems in the recipient areas. At this time, in Manado, short term health programmes were planned for IDPs with the assistance of the Provincial Health Office (PHO) and Ministry of Health (MoH). The Head of the MHO stated:

> *"…when the first IDPs arrived in this area, developing strategic health planning for IDPs and essential health programmes and services were the priorities, and we followed the guidelines created by the MoH to provide short term health programmes and services. At that time technical assistance from central level and provincial levels was available in developing health programmes and services for the IDPs"* (Head of Manado MHO).

The MHO developed health programme plans for IDPs particularly in the development of target priorities, supported by the central and provincial governments. There was considerable extra work involved in implementing these programmes and services which paralleled those for the local community. The Head of MHO said:

> *"…although we got support from MoH and PHO, the implementation of the health programmes provided to the local community was affected and there was work overload"* (Head of Manado MHO).

Moreover, the development of health programmes and provision of health services to the IDPs were still guided by central level. The Head of MHO explained:

> *"…the administration procedures that we used for creating health programmes and providing health services to the IDPs were from the Ministry of Health, we didn't have any standard procedures to provide health programmes and services to the IDPs"* (Head of Manado MHO).

There was a difficulty in implementing the policies from central level. As the Head of MHO explained:

> *"…we were facing difficulties in translating national health policies and adjusting them so that they could be local health policies, including those for the IDPs"* (Head of Manado MHO).

Health programmes and services were initially under the control of the MoH and Provincial Health Office (PHO), while the provision of the services was the responsibility of the MHO. The Head of MHO stated:

> *"…when the IDPs first arrived in Manado we monitored and evaluated the emergency health programmes offered to them together with provincial and central levels. However since last year the monitoring and evaluation of the health programmes has become our responsibility. We conducted health monitoring during visits to the puskesmas and sometimes in local households and these were evaluated during the monthly meeting in the MHO with the puskesmas and the hospital"* (Head of Manado MHO).

Similarly in Sampang, after the arrival of the IDPs the health managerial process was enlarged, particularly in setting up and providing essential health programmes and services to the IDPs. Health programmes and services that already existed had to be adjusted because of the large number of IDPs all arriving at the same time.

The responsibility for administration of health programmes and providing health services to IDPs was increased. The Head of the DHO commented:

> *"…managerial processes such as planning, implementation, monitoring and evaluation of health programmes in the district caused the DHO to increase the workload of the health workforce in order to deal with the health problems brought by the IDPs to this district"* (Head of Sampang DHO).

The organisation of the health programmes of the DHO was also directed by the Central level. As the Head of Sampang DHO commented:

> *"…organisation of health programmes in this district was still directed by the MoH through the PHO, particularly in policy and standard of health services. Some of the health policies from central level that we had to implement at the local level were not suitable for the situation in this district because of our different situation such geography, demography background and pattern of illness of the population"* (Head of Sampang DHO).

Theme 6.2 The Challenges Faced by Both Manado and Sampang in Relation to Providing Health Programmes and Services to the IDPs

At the time this research was conducted the IDPs in both areas had been living there for about 3 - 4 years. Considering that the conflict in their home areas was over, the central government declared that there were no longer any IDPs. The IDPs had been given money as compensation to return to their homeland and start a new life. However, in reality they still lived in the recipient areas with no idea when they would return to their home land. As result, the local health authorities and health management systems, included planning, implementing and monitoring and evaluation, had to remain in operation.

Sub-theme 6.2.1 Planning of Health Programmes and Services

In Manado, the decision of the IDPs to remain in the area had an impact on the MHO's ability to implement planned programmes and services for the local community. As the Head of MHO commented:

> *"…as there was no longer any special treatment for IDPs, we treated them the same as the local community. We had to decide to integrate the essential health programmes for IDPs with the local community's health programmes. This was because, at the end of 2003, central level announced that the IDPs' issues in Indonesia had to be finished on the assumption that conflicts that had exploded in the past years would stop and the IDPs have the opportunity to return to their homeland"* (Head of Manado MHO).

Although the MHO was supported by the MoH and PHO, the planning of health programmes was the main task of the MHO. As the Head of MHO stated:

> *"…health programmes were planned by us and supported by central and provincial levels…the programmes that we developed particularly for IDPs were integrated with health programmes for the local community. At the moment the programmes are for the short term. This is because of the country's political situation. With the imminent election of members of parliaments and the President, we considered the IDPs would return to their homeland"* (Head of Manado MHO).

This research found that, despite the MHO using epidemiological evidence and assumptions based on past experience for strategic health planning for IDPs, dependency on upper levels in health planning was high, particularly reliance on the Minimum Service Standards (MSS) guidelines. As the Head of the MHO commented:

> *"…integration of health planning for IDPs with that for the local community was done in accordance with the MSS produced by central level and we think this is an efficient use of our health resources in this Municipality"* (Head of Manado MHO).

In Sampang, health programme planning for IDPs was also closely related to that for the local community. As the Head of DHO stated:

> *"…in normal conditions our health planning was based on health data collected from the monthly reports of health facilities (hospital and puskesmas). This included the results of monitoring and evaluation of every health programme and monthly meetings between the DHO, the district hospital and the puskesmas"* (Head of Sampang DHO).

Before the arrival of IDPs, the planning of health programmes for the local community was developed by each sub-division of the DHO, based on an annual evaluation and referring to the Minimum Service Standards (MSS). In terms of dealing with the IDPs' health, the planning focused mainly on essential health programmes and services. As the Head of DHO commented:

> *"…the health planning for this district was being done according to the MSS used in all districts of Indonesia"* (Head of Sampang DHO)

> *"…when the first IDPs arrived in this area, in developing strategic health planning for IDPs, essential health programmes were the priority of the programmes and services, and we followed the guidelines created by the MoH. At that time technical assistance from central level and provincial levels was available in developing health programmes and services for the IDPs"* (Head of Sampang DHO).

In this district the process of programme planning was done at the monthly evaluation meeting between the DHO, the *puskesmas* and the district hospital. During the period of this research, the health planning for IDPs was developed along the same lines. However, assumptions from past experience also contributed to the health planning. As the Head of DHO stated:

> *"…in order to develop health planning for the IDPs, we sometimes use assumptions for predicting the diseases, based on our experience in previous years"* (Head of Sampang DHO).

Sub-theme 6.2.2 Provision of Health Services

In Manado provision of health services particularly essential health services is provided by the puskesmas. The drugs and supplies for the *puskesmas* were supplied by the MHO. The drug and medical supplies requests were based on their use by *puskesmas* in the previous month. With the mass movement and extended stay of IDPs to the municipality, this system became overstretched and there was a possibility that the service to the local community might be compromised. As a Head of a Puskesmas stated:

> *"…there was no special provision of drug medical and supplies for IDPs in this sub-district. The demand for drugs and supplies from this puskesmas for IDPs was met from the local community's health services and this depended on our monthly request. When the IDPs first arrived in this areas drug availability was insufficient. Currently there is a shortage of certain kinds of antibiotic, particularly at the end of the month"* (Head of Bengkol *Puskesmas).*

During this research, shortage of drugs and limited availability of medical supplies in the *puskesmas* was an issue, particularly regarding certain types of antibiotics and medical equipment. Observation indicated that medical equipment in the *puskesmas* did not meet the standards specified by MoH. For example, some small items of medical equipment were missing. This condition influenced the provision of health services both to the local community and the IDPs.

In Sampang, as in Manado the implementation of health programmes to IDPs was in line with health programmes provided for the local community. This was because the IDPs had decided to stay in this district for an indefinite time. As the Head of the DHO commented:

> *"…essential health programmes developed by the DHO for the puskesmas were also provided to IDPs"* (Head of Sampang DHO).

> *"…it was difficult for us to conduct the managerial process without the support from the upper level, because we did not have the expertise to deal with a situation like this, where the IDPs had stayed for more than 3 years in these areas,"* (Head of Sampang DHO).

Sub-theme 6.2.3 Monitoring and Evaluation

In Manado, monitoring and evaluation of health programmes in this municipality followed up the progress of the programmes and determined whether or not they had reached their targets, and provided information to feed into the planning for the following year. The MHO used a combination of past experience and guidelines from central level. The Head of MHO stated:

> *"…monitoring and evaluation are based on needs assessment indicators specified in the evaluation guidelines from central level"* (Head of the Manado MHO).

No specific instrument was provided by the MHO for conducting the monitoring and evaluation of health programmes and services. As the Head of the MHO makes clear, the MHO used the guidelines created at central level.

In Sampang, the scheme of health monitoring and evaluation of health programmes and services in current use by the local community and IDPs was described by the Head of the DHO:

> *"...every 3 months the person who was responsible for the programme in the DHO visit the puskesmas to conduct monitoring and evaluation. Each programme holder visits independently of the others. The purpose of these visits is to supervise the health programme and service activities. Sometimes that person visits households in the catchment area of a puskesmas in order to collect information about the current health status of the local community. The programme holders extended their monitoring and evaluation activities to cover the IDPs"* (Head of Sampang DHO).

There was a regular monthly meeting in the capital of Sampang District to evaluate the progress of health programmes implemented by the *puskesmas* for the local community as well as the IDPs. According to the Head of DHO:

> *"…data collected from monitoring and evaluation are analysed and the results used as inputs to improve all the health programmes provided in the district. But we have to admit that the capability of the DHO health staff is weak. Those particularly responsible for the health programme were required to improve their capacity in terms of how to collect the information and analyse it as part of the implementation of the health programmes and services"* (Head of Sampang DHO).

This research found there were no specific guidelines for monitoring the evaluation of the health programmes and services created by DHO. The DHO was using the general guidelines provided by central level.

It was found both MHO and DHO organisations used reports from *puskesmas* in similar formats developed by central level as their main form of monitoring and evaluation. Monitoring and evaluation of health programmes and services within the M/DHO was carried out by using these reports for analysis and review, however, feedback to the *puskesmas* was infrequent. Several health programmes also utilised field visits for monitoring. This activity, often done by M/DHO and the health officers, was intended to verify the regular reports from the *puskesmas.*

Theme 6.3 The General Effect of Health Decentralisation Policy on Local Health Systems

Since this policy was implemented in 2001, the health programmes for the community and the IDPs, including the organisation and execution of the service, had become the full responsibility of the M/DHO and puskesmas in both field areas. This research was focused on the general effect of health decentralisation policy on routine management and performance of health programmes and services of the M/DHO; the health workforce; the provision of drugs, medical supplies and equipment, and financial support.

Sub-theme 6.3.1 Management of Health Programmes and Service

The M/DHO became increasingly responsible for the planning, organisation and delivery of health services under the terms of health decentralisation policy. This research found the functions of the M/DHO had become broader. Its role, which had previously been only technical and administrative supervision, now included the creation of new concepts of programmes, the organisation and provision of health services based on the specific or type of area. As the Head of MHO stated:

> *"…(after) health decentralisation policy …..… many of the MHO functions were dramatically changed, including that now we have to develop the health programmes and provide services to the community as well as to manage them"* (Head of Manado MHO).

At the time of the research, health decentralisation had effectively taken place but the procedures for developing health planning for the municipality and district continued to be based on central level health guidelines. As the Head of MHO commented:

> *"…planning of health programmes and services was formulated by the MHO and with guidance from central level, consolidated by the Municipal government and the Provincial Health Office. However the role of the Provincial Health Office was unclear because the policy came from central level"* (Head of Manado MHO).

During the decentralisation policy the M/DHO had to develop their own health priorities based on the health needs of the local people. The health programmes and services had to be extended and the health decentralisation policy was still ongoing. As the Head of MHO stated:

> *"…the elements and work implications of the health decentralisation policy had to be disseminated to the health staff, and the attached key steps in the health decentralisation policy provided by central government had to be adjusted and suited to the identified areas"* (Head of Manado MHO).

Moreover, monitoring and evaluation of health programmes and services to the population were influenced by health decentralisation policy. Monitoring and evaluation provided information on the current position, on the impact and on the appropriateness of decisions about health programmes and services. In Manado, as the Head of MHO stated:

> *"…health activities in this municipality were monitored and evaluated every month and at an annual meeting; this included monitoring of planning that we already set up last year and progress of the implementation of the health programmes. Financial flow and allocation were also monitored; this included checking the budget from different sources such as the general and special allocation fund, the loan fund for health development and the fees for services collected by the puskesmas"* (Head of Manado MHO).

In 2003, following the revision of the health decentralisation policy by the Ministry of Health, the Manado MHO had to adjust its management of health programmes and services for the local community and the IDPs. This caused some delays in developing health programme planning for the population. As the MHO said:

> *"…in the past two years it has been difficult for us to set up long term health programmes. The health programmes that we conducted were short term programmes, because of the change of health decentralisation policy. We have to adjust our organisational structure, to accommodate the elements of health decentralisation policy so that the health workers will work effectively according to their job description"* (Head of Manado MHO).

In Sampang, it was noted that the initial period of decentralisation was very difficult. The DHO was modifying the structure of organisation. As the Head of DHO said:

> *"…the structure of the health organisation of the DHO was adjusted in terms of involving and sharing responsibility equally within the sub-divisions, in order to create the health programmes and provide the services delivery to the community and IDPs, based on their needs. The new structure of health organisation is now about three years old and we have needed this period and possibly longer to assess its suitability for this district and to put the right health worker in the right position"* (Head of Sampang DHO).

The planning, implementation, monitoring and evaluation of health programmes and health services to the population were influenced by the health decentralisation policy. The district has been shift to the technical health institution to the developing and creating health programmes and services based on their local health needs.

As the Head of Sampang DHO commented:

> *"…the planning, implementation and monitoring and evaluation of health programmes and providing health services to the population including IDPs is totally influenced by the health decentralisation policy which is currently being implemented. We have to develop our health programmes based on the demographic characteristics of the population and the topography of this area"* (Head of Sampang DHO).

Although health programmes and services were based on the MSS, the monitoring and evaluation conducted by the DHO often included regular evaluations conducted either during programme implementation or at the end of the fiscal year.

The developing situation strained the health resource capacity. Numbers and qualifications in the workforce, financial support for health programmes and services, the provision of drugs, medical supplies and equipment, and the capacity of health resources in selected *puskesmas* were all affected.

> *"…although we got support from PHO and MoH, the implementation of the health programmes provided to the local community was affected and there was work overload"* (Head of Manado MHO).

Sub-theme 6.3.2 Health workforce

In Manado, referring to the data from health profile 2003, the health workforce was adequate in terms of numbers, qualification and specialities (Table 6.1). This was because Manado municipality had a referral hospital that catered for several provinces surrounding North Sulawesi Province. The hospital was also a teaching hospital for medical students.

Table 6.1: Distribution and qualifications of the health workforce in Manado Municipality (Dinkes Manado, 2003).

Qualification	Provincial General Hospital	Mental Hospital	Municipal Health Office	*Puskesmas*	Private Hospitals and Maternity Clinics	Total
Medical Doctors	315	9	13	37	46	420
Midwives and nurses	587	129	22	210	229	1,177
Pharmacists	37	5	7	14	12	75
Nutritionists	39	6	2	12	5	64
Sanitarians	14	3	13	27	2	81
Medical Technicians	53	2	0	2	15	72
Public Health Staff	0	0	4	3	0	7
Total	**1,045**	**154**	**61**	**305**	**309**	**1,896**

Although the MHO determined the need in terms of number and qualifications of the health workforce for its area, the supply of the medical doctors in the municipality depended on central government despite decentralisation. As the Head of MHO commented:

> *"…nowadays the health workers are controlled by our office because of health decentralisation policy. However, we depend on central government to provide the qualified medical doctors"* (Head of Manado MHO).

A problem faced by the MHO was also the capability of the health workers in creating local health policies and translating the policies from central level into local health policies. As the Head of the MHO said:

> *"…we have had difficulties in terms of applying the national health policies to the local situation because we don't have enough skills. We need training and short courses related to the health policies"* (Head of Manado MHO).

Although the numbers in the health workforce in Manado municipality were sufficient, their deployment to relevant postions was inadequate or inappropriate for their responsibilities. For example, according to Head of Bengkol *Puskesmas:*

> *"….someone with expertise in environmental health was given a position in immunisation"* (Head of Bengkol *Puskesmas*).

In Sampang, as this research found, the health workforce availability in the DHO was a factor in their ability to provide health services to the IDPs. Table 6.2 below shows the distribution of the workforce in public health facilities; that is, the DHO, the hospital and *puskesmas.* All the health facilities in Sampang District were supported by medical doctors, paramedics and other staff including medical technicians and public health administrators.

Table 6.2: Distribution and qualifications of the health workforce in Sampang District (Dinkes Sampang, 2003).

Qualifications	District Health Office	District Hospital	*Puskesmas*	Total
Medical Doctors	2	10	28	40
Midwives and nurses	7	40	219	266
Pharmacists	2	4	5	11
Nutritionists	4	2	20	26
Sanitarians	9	1	8	18
Medical Technicians	0	6	4	10
Public Health Staff	5	0	0	5
Total	**29**	**63**	**284**	**376**

Over the year the health workforce numbers in the district changed because the turnover was high, particularly among the medical doctors. As the Head of the DHO stated:

> *"…turnover of medical doctors is high in this district because most of them are under contract for only three years. In addition, there is a psychological barrier between the medical doctors working in the puskesmas and the programme managers in the DHO because of their differing levels of education; many of the programme holders graduated from an academy rather than a faculty. At the moment it is difficult to find staff with suitable qualifications to become programme holders at the DHO, because it depends on the availability of qualified health personnel at the local government as well as at provincial and central levels. This condition is aggravated by the district not being an attractive place in Indonesia for the newly graduated, either medical doctors or paramedical staff"* (Head of Sampang DHO).

At the time of the field research, there was a lack of competence among the health workforces in terms of procurement of drugs and supplies, including organising supplies from drug companies to the district's drugs and supplies warehouse. This was because the health officers had no expertise in procuring the drugs and supplies. As the Head of the DHO stated:

> *"...the DHO lacks people who have the capability and skills in writing technical specifications for drugs and supplies, supervising competitive bidding or monitoring and evaluating contract performance. There is also a lack of skill in management relating to the monitoring of quality, in some cases drugs, medical and equipment supplies did not meet the expected standards"* (Head of Sampang DHO).

The research found that the DHO endeavoured to improve knowledge and skills in management techniques and the capability of the existing DHO staff. There was a concentration on improving the abilities of staff in the analysis of local health problems, strengthening staff capability in district health planning, strengthening their leadership skills and improving motivation. In order to improve the capacity of the health workforce in Sampang District, the DHO took the initiative in encouraging them to take non-degree or degree courses, either domestically or internationally as well as running training courses. As the Head of DHO stated:

> *"…theoretically the health workforce in all puskesmas in this district have the opportunity to take training or to improve their professionalism in handling health issues, but this depends on the MoH and PHO's decisions because the financial support comes from the upper levels"* (Head of Sampang DHO).

Attracting doctors, midwives and nurses as well as health administrators to work in remote places by providing incentives and facilities still does not guarantee that the workforce, particularly doctors, would remain in this district after their contract with the government is finished. As the Head of Bunten Barat *Puskesmas* said:

> *"…when my contract with the government terminates I'll move to the city and will train to specialise in surgery"* (Head of Bunten Barat *Puskesmas*).

The contract is with the central government and is in relation to new doctors in general practice or a specialist post. The contract requires them to work in rural areas for a period of time; three years for general practitioners and two years for specialists.

Following health decentralisation, there have been significant changes in the deployment of the health workforce throughout the district. For example, health workforce deployment was now governed by which health facilities needed them, whereas previously it depended on provincial policy. As the Health of DHO commented:

> *"…although the health workforce depends on the local and central government, deployment of the health workforce in puskesmas, the District Hospital and the DHO is based on the needs of the institutions and also the available expertise of the health workforce. The DHO is responsible for deploying the health workforce"* (Head of Sampang DHO).

The deployment of the health workforce influences the health status of the local community as well as the IDPs. This research found the health workers preferred to work in the urban area rather than in the rural areas as illustrated by the following statement:

> *"…some of the medical doctors did not like living in the puskesmas. They lived in the capital city of the district and they went to the puskesmas to do the job during office hours. In recent years, there have been several attempts to persuade health professionals, especially doctors, to commit to the health issues in Sampang District through incentives, housing, training and continuation of education in specialist administration"* (Head of Sampang DHO).

Imbalances in geographic distribution, especially between urban and rural areas influenced the number and qualification of the health workforce in these two areas.

Sub-theme 6.3.3 Provision of Drugs, Medical Supplies and Equipment

The reliable availability of drugs, medical supplies and equipment in public health facilities, could contribute to maintaining the IDPs confidence and trust in the health services. In addition, making essential drugs, medical supplies and equipment equally available for the local community and IDPs' is a key condition for improving health status.

In Manado, drugs and supplies for the *puskesmas* were supplied by the MHO. Requests for drugs and medical supplies were based on their use by *puskesmas* in the previous month. With the mass movement of IDPs to the municipality this scheme was inadequate and there was a possibility that the service to the local community might be compromised. It was thus necessary for the MHO to increase the provision of drugs and supplies to the *puskesmas*. As a Head of *puskesmas* stated:

> *"…we have to put in a request for the drug and medical supply every month to the MHO in order to fulfil our needs in this puskesmas. The request is based on the previous month's use"* (Head of Bengkol *Puskesmas*).

> *"…there was no special provision of drug medical and supplies for IDPs in this sub-district. The demand for drugs and medical supplies from this puskesmas for IDPs was met from the local community's health services and this depended on our request every month. When the IDPs first arrived in this areas drug availability was insufficient. Currently there is a shortage of certain kinds of antibiotic, particularly at the end of the month"* (Head of Bengkol *Puskesmas*).

The MHO approached the local government to obtain more money to support the provision of drugs and supplies. As the Head of MHO explained:

> *"…because of the IDPs' health needs, we had to approach the local government to allocate more money in their budget for purchasing drugs and supplies. The local government allocates a certain amount of money as a budget supplement to the central health budget in every year"* (Head of Manado MHO).

The procedure for purchasing drug and supplies for the *puskesmas* involves a bidding process; that is, tenders are sought from private companies. As the Head of MHO illustrated:

> *"…providing puskesmas with drugs and medical supplies including medical equipment from the MHO is a very complex process and involves a large variety of people from both the private and public sectors. In the bidding for the drugs and medical and equipment supplies sometimes there were calls from local politicians or members of the local parliament or their families to support the bid of their favourite private company. This intervention sometimes made it difficult for the bidding committee to decide who should provide the drugs, supplies and medical equipment. Moreover, some of the medical equipment supply was the responsibility of the central authority"* (Head of Manado MHO).

In Sampang, drugs and medical supplies for the *puskesmas* came from the DHO's drugs and supplies warehouse. As in Manado, every month the *puskesmas* had to request drugs and medical supplies from the DHO based on the amount used the previous month. Procurement of drugs through a bidding process was similar to Manado.

Availability of drugs and supplies in the *puskesmas* sample in Sampang was adequate except that the supply of several kinds of antibiotics did not last to the end of the month. As one respondent Head of a *puskesmas* illustrated:

> *"…supply of drugs and supplies in this puskesmas was based on the incidence of diseases. For example, last month we estimated the need for drugs and supplies based on the disease pattern in this sub-district. The list of requests was sent to the DHO and the DHO reviewed it. After approved by DHO we will collect them from the district warehouse pharmacy. Our experience is that the DHO will approve only half the amount we request. The result is that at the end of the month we will be out of stock of the antibiotics. This situation has an impact on the patients who need antibiotics"* (Head of Robatal *Puskesmas*).

Sub-theme 6.3.4 Financial Support for Health Programmes and Services

The budget support for the public health sector was provided by the government, both central and local (as explained in Chapter Three). Demand for health services by the IDPs in the municipality and the district increased the budget for health development, particularly for health services for IDPs. Funds for the IDP services had been channelled from the MoF (Ministry of Finance) through the district administration before they reached the MHO and DHO. This financial support for IDPs came from a national budget called 'Special Allocation Funds' (DAK). The purpose of this budget was to help in meeting the needs of the area and was based on the specific health programmes operating there.

In Manado, the budget that was allocated for health development and the budget for IDPs' health came from different sources. As the Head of MHO commented:

> *"…one of our policies for IDPs was that they will be treated in the same way as the local people. The budget for support of their health came from the municipality's health budget and the national budget. In 2002, the operational budget for health development was derived from several sources. Of the total, 58.30% was from the local budget, 15.12% from the provincial budget, 0.25 % from the national health budget and 26.33% from foreign loans"* (Head of Manado MHO).

Certain procedures have to be followed by the MHO in order to get funding support from Local Government. As the Head of MHO stated:

> *"…in order to get the budget from the local government, the MHO has to request a specific amount of money from the municipal government, which will then consider the per capita income of the local community. The budget allocated by the local government was very limited and made up only 3.23% of the total budget for municipal development. The budget was for health programmes and services, including maintenance of the equipment and facilities in the MHO and puskesmas"* (Head of Manado MHO).

The budget that supports the health programmes and projects came from several sources, was monitored every 3 months through progress reports and was audited by outside institutions such as the Bureau of Financial Control. As the Head of MHO commented

> *"…controlling of the budget spent on health programmes and services in this area were done by Bureau of Financial Control from provincial level"* (Head of Manado MHO).

In Sampang, as in Manado, the budget for health development came from central, provincial and local sources. According to the Head of DHO:

> *"…in 2002, of the total health budget in this district, 4.52% came from the local government, 15.60% from the provincial government, 50.08% from the national health budget and 29.80% from foreign loans"* (Head of Sampang DHO).

The methods for controlling the budget were also similar to Manado, as was the budget flow after decentralisation. As the Head of DHO stated:

> *"…every six months the health budget in this area is audited by the Provincial Bureau of Financial Control*" (Head of DHO)

The DAK funds were allocated to the health programmes and activities of the DHO and *puskesmas* in this district. As the Head of DHO commented:

> *"…at the moment, the budget for health programmes and services for IDPs, particularly from the DAK sources is sufficient and … the DAK allocation is mostly spent on drugs and medical supplies, equipments, buildings and mobile clinics' maintenance both in the DHO and the puskesmas"* (Head of DHO).

The financial arrangements for the support of health programmes and services to IDPs in Sampang District were thus reliant on central level support. There was limited financial support available from local resources for local community and IDPs' health.

The financing and the development of health programmes, including providing health services to IDPs, are directly related. This research found that, in financial matters, in addition to finance from local sources the Manado MHO required some support from the central level budget allocation. The Sampang DHO was heavily reliant on it, which meant that their financial autonomy was less than that of Manado.

Theme 6.4 Coordination of Health Programmes and Services for IDPs

Many solutions to health problems require coordination between the MHO and PHO as well as the MoH. Internal coordination of health programmes and services within sub-divisions in M/DHO for health programme development and health services is important. Health programmes that are to be implemented for the IDPs will be more effective through coordination. In addition, coordination of health programmes between the MHO, DHO and inter-related sectors is important. Other sectors, such as those providing family planning, sanitation, and building health facilities can have a greater impact on health than health services; for example, health programme coordination between the M/DHO and Bureau of Family Planning and Department of Public Works.

Vertical coordination between the M/DHO and the upper levels (MoH and POH who provide technical assistance to the M/DHO) is important in relation with the implementation of policy and standards of health services to the IDPs. Horizontal coordination between the M/DHO and NGOs is also significant in terms of providing health services to the IDPs.

Success of the health programmes in fulfilling the health needs of a community and IDPs depends on coordination. Better coordination between the M/DHO and PHO as well as MoH including related public sectors and NGOs is one of the important factors that could improve the health status of IDPs living in temporary accommodation in the recipient areas.

Sub-theme 6.4.1 Coordination of Health Programmes and Services between Local Government and Related Public Sectors

After decentralisation policy in Municipality and District coordination of health programmes for IDPs with local government and related sectors had been important since the local government became responsible for all programmes in the Municipality and District. In Manado, the Head of MHO realised coordination with other sectors was an important factor in achieving adequate coverage of health programmes and services for both the community and the IDPs. As she said:

> *"…collaboration with related sectors is one of our strategies for achieving the objectives of health development in Manado municipality. In practice, the development of collaboration with the other sectors especially during the meetings in the Municipal office was smooth following the agreement of certain responsibilities relating to improving the health of IDPs. However, the actual implementation of the programmes was sometimes difficult because the other sectors were working with and focusing on their own programmes"* (Head of Manado MHO).

Coordination arrangements with related sectors often took place when the MHO was attending the three monthly coordination meeting in the municipal office. As the Head of MHO stated:

> *"…the purpose of regular meetings in the Municipal office was to synchronise the health programmes with the other sectors' programmes that related to health"* (Head of MHO).

The research confirmed that the health programmes and services provided by the MHO and *puskesmas* for the IDPs were synchronized and reported to the local government through the *Satkorlak PBP* as explained in Chapter Two**.** The process of providing health programmes and services to the IDPs from planning and implementing to monitoring and evaluation were regularly reported. As the Head of Manado MHO commented:

> *"…attempts to coordinate the health programmes and services provided for the IDPs were complicated, particularly in the first year of the IDPs arrival in this area. This was so even though the regular meetings were held and agreements reached on the best strategy to be implemented in the field, based on the capability of every sector" (*Head of Manado MHO*).*

> *"…the other approach to coordination between sectors of local government, particularly in complex emergency situations, was through Satkorlak and Satlak. This seemed to be a good idea and many believed that it would achieve effective and efficient programmes for the IDPs. This coordinated approach to a given situation as the only way to achieve coherent and worthwhile results seems not to be working, because every sector focused on their own programmes agenda"* (Head of Manado MHO).

During the research, the coordination of health programmes for IDPs between MHO and related sectors was inactive and the MHO was working within its own programmes. The role of the *Satkorlak PBP* and *Satlak* had become less active since year 2004. This situation might contribute to less effective and sustainable health programmes and services to the IDPs. In addition, it was found that the other sectors related to health did not always share their programme details so that they could be integrated with the IDPs' health programmes and services. They would choose to carry them out according to their own guidelines. Every sector was working to its own agenda.

In Sampang, in order to implement the health programmes and services, the DHO collaborated with other related local departments because the DHO is also part of local government. Coordination with related sectors such as the District Social Office, the District Education Office, the Public Works Office and the Bureau of Family Planning is the approach used to achieve the objectives of health development in Sampang District by the DHO (Sampang Health Profile, 2002).

In this research, the DHO along with the *puskesmas* collaborated with other sectors related to health programme activities such as improving the family planning programme supported by the local Bureau of Family Planning; environmental health and water supply with the Public Works and social issues with the local Social Department. As the Head of Sampang DHO stated:

> *"…there was good collaboration with the other sectors, especially during the meetings in the Local Government district office, where the agreement on the implementation of certain responsibilities related to improving health for IDPs was reached. However, actual implementation was un-integrated because the priorities of the various sector programmes did not match and every sector focused on its own programmes"* (Head of Sampang DHO).

As noted for Manado MHO, at the time of the research, the *Satkorlak PBP* and *Satlak* were less involved in health matters as the IDPs had by that time stayed for more than 3 years. The Head of the DHO commented:

> *"…the activities of the Satkorlak PBP and Satlak in the district are no longer the same as in the first year of the IDPs arrival, when the organisation was very proactive. Nowadays, we just send a formal report concerning the health programmes and services for IDPs to that organisation"* (Head of Sampang DHO).

The winding down of the activities of *Satkorlak PBP and Satlak* in coordinating the work of other sectors was yet one more change to be accommodated by the DHO. However, the process of reporting on the IDPs' health continued. Moreover, as the Head of the DHO stated:

> *"…coordination of health programmes was difficult in this area because every sector was working to their own agenda and it was also difficult for the various sectors to integrate their programmes, since the time allocated to implement them and the budgets allocated for their support were for different purposes. In that situation the overlapping of services to IDPs by different sectors cannot be avoided"* (Head of the Sampang DHO).

Since the beginning of the decentralisation policy, the relationship of the MHO and DHO with the local government (regent or mayor's office) was very important, particularly in obtaining political and budget support from local resources.

Sub-theme 6.4.2 Coordination of Health Programmes with the MoH and POH

In Indonesia the impacts of conflicts, disasters and all major natural and man-made catastrophes require a national response, including the safeguarding of the health of IDPs' (MoH, 2001b). The MoH and PHO make considerable efforts to deal with IDP health issues and to assist the M/DHO.

In Manado, coordination of health programmes between the MHO and the upper level (MoH and POH) had been an important issue since decentralisation began. At the time of the research the role of the upper level was indispensable in terms of providing technical assistance to the MHO, particularly in developing policy and health resources. The health programmes and services provided to the IDPs followed the guidance given by central level and were controlled by the PHO. In such a setting, coordination and monitoring of health programmes and services to local people and IDPs were essential. As the Head of the MHO stated:

> *"…we have to send monthly reports on morbidity, mortality, availability of drugs and supplies, and utilisation of health services as well as the IDPs' health status to the provincial and central levels. Every month an inspection of the health programmes and services is done by the PHO"* (Head of Manado MOH).

Health programme and service coordination between the MoH and PHO as well as the MHO were strengthened after the IDPs arrived in the municipality. At the time this research was conducted the coordination of health programmes and services between the local MHO and the upper levels had matured. There appeared to be coordination of efforts at all levels. As the Head of MHO stated:

> *"…the health programmes and services for the IDPs has been merged with those for the local community, regular communication relays the health status of the IDPs to the MoH and PHO every month, through the monthly reports from us and monthly supervision and support from PHO"* (Head of Manado MHO).

In Sampang, as the recipient of the IDPs, the DHO relied not only on the MoH and PHO for proposals for suitable programmes and services but also on human and financial resources to support the health programmes and services. As the Head of DHO stated:

> *"…this district is the poorest in this Province and is not attractive to health workers particularly the doctors. In dealing with the health issues of the IDPs we really depended on higher level support in the provision of health resources"* (Head of Sampang DHO).

At the time of conducting this research the role of the central and provincial levels concerning the IDPs' health issues had been significantly reduced. As the Head of DHO stated:

> *"…we dealt with the health programmes and services for IDPs, the intervention of the central and provincial level was minimal although we relied on them"* (Head of Sampang DHO).

In general, coordination of health programmes between the Manado MHO and Sampang DHO with the PHO and MoH was still a strong feature because the two institutions continued to rely on the guidelines from PHO and MoH and also for technical assistance. The difficulty the M/DHO experienced in translating the health policies from central level had hindered the implementation of the health policies at local level that is diffent in terms of local specific of municipal and district in terms of geography, demography background of the population and topography

Sub-theme 6.4.3 Coordination of Health Programmes with NGOs

This research identified the role of NGOs as being an important form of support to the local resource capacity. As the Head of Manado MHO commented:

> *"…the role of NGOs in protecting and assisting IDPs, particularly in supporting health infrastructures and services, has contributed to maintaining the health status of IDPs in our area"* (Head of Manado MHO).

In Manado, several International NGOs including Medecins Sans Frontieres (MSF), International Medical Corps (IMC), Consortium for Assistance and Recovery toward Development in Indonesia (CARDI), Church World Services (CWS) and local NGOs were all working with health programmes for IDPs in Manado's temporary accommodation.

Most NGOs were at work in the first year after the IDPs arrived. As the Head of MHO said:

> *"…in the first year when IDPs arrived in this Municipality, the NGOs were very helpful to the IDPs and also to us as public health providers, particularly in supporting the infrastructure such as water supplies, latrines and standard medical equipment for primary health care. However, some of the health programmes overlapped with the essential health service programmes that we provided to the IDPs, such as MCH and basic medical treatment. We had regular meetings with NGOs, but we have to admit that in the field implementation of the programmes there was less coordination because the NGOs focused on their own programmes that they were already carrying out and we were also working with the priority programmes that we had already developed"* (Head of Manado MHO).

During the data collection, there were no NGOs working in the temporary accommodation. However, according to the Head of MHO:

> *"…last year the NGOs, particularly International NGOs, stopped their programmes in this area. I don't know the reason why they stopped, but I think this was related to the central policy that said the IDPs issues had to finish in December 2003. On the other hand, the support of international agencies and NGOs was very helpful both for the MHO and IDPs, particularly in supporting health infrastructures and medical equipment"* (Head of Manado MHO).

In Sampang, after the IDPs arrived, the international NGOs included World Vision, Mercy Corps, Red Crescent, and IMC (International Medical Corps). Local NGOs also gave support. Unfortunately, sustainable support of the programmes by NGOs was limited only to the certain health programmes such as MCH, Health Environment and basic medical services,

The problem facing NGOs in the provision of the services was coordination of their programmes with the DHO. The NGOs came with their own health programmes that were not flexible enough to integrate with the health programmes and services provided by the DHO. According to the Head of DHO:

> *"…even though the NGOs were communicating their programmes to us there was no real integration with our health programmes and services to the IDPs"* (Head of Sampang DHO).

At the time of the research there was no health support from NGOs for IDPs in Sampang District; but according to the Head of DHO:

> *"…the NGOs who previously worked in the health area also helped with the health infrastructure and placed more emphasis on health promotion and prevention"* (Head of Sampang DHO).

This research found, there was some cooperation between the NGOs and the local health authority, but it was only to report the NGOs' activities rather than to incorporate their programmes and services along with those of the local health authority.

Both in Manado and Sampang, although there was overlapping of health programmes between health authorities and NGOs, the NGOs played a key role in the health care for IDPs. Many benefits accrued from the NGOs' activities. They provided health care services, spread health education and were involved in promotion and support for health infrastructures as well identifying health problems and giving information to the IDPs.

Theme 6.5 Capacity of Health Resources in Selected *Puskesmas*

Health resources in *puskesmas* are important because they are the front line for providing health services to the IDPs. Health resources in these institutions are to promote affordable access to health care services to the populations of sub-districts. This research found that health resources in the *puskesmas* studied were limited as to the capacity of health workforces, equipment and facilities to support the health services and to assure their availability.

Sub-theme 6.5.1 Capacity of Health Resources in Selected *Puskesmas* in Manado

In Manado, there are 13 *puskesmas* spread in 9 sub-districts two *puskesmas* were chosen for this research, Paniki Bawah and Bengkol because these *puskesmas* covered the IDPs in Mapanget Sub-district.

These two *puskesmas* provided health services to the 9,070 households in the sub-districts. According to the census in 2002, 37,738 people including 3,805 poor people lived in 11 villages (Dinkes, 2003).

The workforce in Paniki Bawah *Puskesmas* was larger than that in Bengkol *Puskesmas* (Table 6.3). This was because the Paniki Bawah *Puskesmas* covered a larger population than Bengkol *Puskesmas*.

Table 6.3: The Workforce at Bengkol and Paniki Bawah *Puskesmas*
(Dinkes Manado, 2003)

Health Workforce	Bengkol	Paniki Bawah
Doctors	1	3
Dentists	-	-
Midwives	4	9
Nurses	6	10
Assistant Pharmacists	1	2
Nutritionists	1	1
Laboratory Analysts	-	-
Sanitarians	2	1
Vaccinators	-	-
Health Administrators	-	1
Total	**15**	**27**

There are a number of facilities that support or extend the work of the *puskesmas* (Table 6.4 below). However, these two puskesmas in Mapanget Sub-district do not offer in-patient services because Manado Municipality has several private clinics and hospitals and a provincial hospital that provide services to the local community.

Table 6.4: Health Support Facilities available at the *Puskesmas* in Manado Municipality
(Dinkes Manado, 2003)

Health Support Facilities in *Puskesmas*	Bengkol per unit	Paniki Bawah per unit
Pustu	2	5
Pusling	-	-
Beds	-	-
Posyandu	8	19
Village Maternity Clinic	-	-
Laboratories	-	1
Motorcycles	-	1
Cool Containers	1	1
Vaccine carriers	3	6
Electricity	+	+
Office Support	+	+

The health resources available in the two *puskesmas*, particularly infrastructure and medical equipment, were limited. As the Head of Bengkol *Puskesmas* commented:

> *"…we requested an ambulance and additional health equipment for basic medical services but the MHO said that we must wait for approval at central level because, according to the health officer in the MHO, the budget for purchasing the equipment comes from central level"* (Head of the Bengkol *Puskesmas).*

A simple laboratory as a diagnostic support and an ambulance were also absent in Bengkol *puskesmas*. According to the Head of Bengkol *Puskesmas*:

> *"…we don't provide a laboratory service for this community because we do not have a qualified laboratory analyst"* (Head of the Bengkol *Puskesmas).*

In Paniki Bawah *Puskesmas* there was a simple laboratory but it was not operational. As the Head of *Puskesmas* commented:

> *"…the equipment of this laboratory is complete but neither the reagents nor the paint are available. Moreover, at the moment we do not have a laboratory analyst to operate this simple laboratory"* (Head of Paniki Bawah *Puskesmas*).

Sub-theme 6.5.2 Capacity of Health Resources in Selected *Puskesmas* in Sampang

In Sampang, at the time of the research this district had 20 puskesmas dispersed over 12 sub-districts; The research focused on three sub-districts in Sampang District, Ketapang, Banyuates and Robatal. Each of these sub-districts had 2 puskesmas. The health resources such as the health workforces and particularly the health infrastructure elements of the three sub-districts will be outlined.

Ketapang sub-district had 2 *puskesmas*, Ketapang and Bunten Barat. These covered 20,249 households or 71,351 people including 6,489 poor people who lived in 14 villages (Dinkes Sampang, 2002). Ketapang *Puskesmas* provided not only health services for out-patient care but also had 10 beds for in-patient care, while Bunten Barat *Puskesmas* provided only out-patient/ambulatory care (Dinkes Sampang, 2003).

Banyuates sub-district had 2 *puskesmas*, Banyuates and Bringkoning. These two provided health services similar to other *puskesmas* in Sampang District, except that they did not provide in-patient care. These *puskesmas* covered 16,652 households or 66,022 people, including 5,324 poor people, who lived in 20 villages. (Dinkes Sampang, 2002).

Robatal sub-district had 2 *puskesmas*, namely Robatal and Karang Penang. These *puskesmas* provided similar health services to other *puskesmas* in Sampang District, except that they did not provide services for in-patients. These *puskesmas* covered 23,441 household or 96,655 people, including 6,157 poor people who lived in 16 villages (Dinkes Sampang, 2002).

Health workforces in six selected puskesmas in Sampang District were limited and only that of Ketapang *Puskesmas* had a full staff, as shown in Table 6.5.

Table 6.5: Health workforce in the *puskesmas* in Sampang District
(Dinkes Sampang, 2003)

Health Workforce Category	Ketapang	Bunten Barat	Banyuates	Bringkoning	Robatal	Karang Penang
Doctors	2	1	2	1	2	1
Dentists	1	-	1	-	-	-
Midwives	12	5	12	4	10	4
Nurses	9	4	9	5	9	3
Assistant Pharmacists	1	1	1	1	-	-
Nutritionists	1	-	1	-	2	1
Laboratory Analysts	1	-	1	-	-	-
Sanitarians	1	-	1	-	1	-
Vaccinators	1	-	1	-	1	-
Health Administrators	2	-	1	-	1	-
Total	**31**	**11**	**30**	**11**	**26**	**9**

In addition, health facilities and equipments in six selected puskesmas in this district were limited and only Ketapang *Puskesmas* was complete as shown in Table 6.6.

Table 6.6: Health Support Facilities available at the *Puskesmas* in Sampang District (Dinkes Sampang, 2002).

Health Support facilities in *Puskesmas*	Ketapang	Bunten Barat	Banyuates	Bringkoning	Robatal	Karang Penang
Pustu	3	-	5	-	3	-
Pusling	1	1	1	1	1	1
Bed	10	-		-	-	-
Posyandu	44	20	25	18	23	17
Village Maternity Clinic	6	2	7	3	6	2
Laboratories	1	-	1	-	-	-
Motorcycles	2	-	2	1	1	1
Cooler Containers	1	-	1	1	1	1
Vaccine carriers	5	2	5	3	4	2
Electricity	+	+	+	+	+	+
Office Support	+	+	+	+	+	+

The research found there was a lack of maintenance of the facilities because of the limited budget that was allocated to the *puskesmas*. As one Head of a *puskesmas* said:

> *"…budget allocated by DHO for the maintenance of the puskesmas buildings is low". The budget allocated for maintaining the pusling and motorcycles is also minimal. To maintain these facilities we use the money from the fees that the DHO returns to this puskesmas, but it is not enough"* (Head of Ketapang *Puskesmas*).

In terms of availability of equipment in the laboratories of the *puskesmas,* in Sampang they were better equipped than those in Mapanget Manado, although some lacked a person in charge and reagents. As one Head of a *puskesmas* commented:

> *"…the equipment of this laboratory is complete but neither the reagents nor the diagnostic paint are available. Moreover, at the moment we do not have a laboratory analyst to operate this simple laboratory"* (Head of Banyuates *Puskesmas*).

In general, there were differences between the workforces in the puskesmas in Manado and Sampang, in terms of expertise and distribution. Manado lacked laboratory expertise. The health workers in Manado, particularly the medical specialists, were concentrated in hospitals both public and private, whereas the medical specialists in Sampang were in public hospitals only and were limited to four specialities i.e. obstetrics and gynaecology, paediatrics, surgery and internal medicine.

In terms of health support facilities, *puskesmas* in Sampang were better equipped than those in Manado.

Theme 6.6 Health Service Provision through selected *Puskesmas*

As stated in Chapter Three, the function of the *puskesmas* is to deliver health programmes through providing health services to the whole population in the catchment area. The *puskesmas* is also the technical organisation for health of the sub-district government. This research found the implementation of health programmes, fees for services and services management of the puskesmas are as stated below.

Sub-theme 6.6.1 Implementing the Health Programmes

In Manado there are two *puskesmas* responsible for the health of the IDPs in Mapanget Sub-district. Every year, in order to implement the programmes and provide the health services, these two *puskesmas* and the MHO confer on what particular health programmes and services would be implemented in Mapanget Sub-district. The health programmes and services are usually based on the evaluations of the previous year. Organisation of health programmes and services in *puskesmas* was under the supervision of the MHO. As the Heads of *Puskesmas* stated:

> *"…the health programmes and services in this puskesmas are controlled by the persons from the MHO who were in charge of the health programmes. In addition in every month we have to send a report to the MHO"* (Head of Paniki Bawah *Puskesmas*).

> *"…there was a monthly meeting in the MHO to consolidate the health programmes and services and to evaluate them. The purpose of the meeting is mainly to evaluate the progress of health programmes and services that were being implemented for the local community and IDPs. The meeting also identified new strategies to handle health problems"* (Head of Bengkol *Puskesmas*).

As in Manado, six *puskesmas* were selected for this research in Sampang and the functions of the puskesmas were similar. Implementation of health programmes were under the supervision of the District Health Office. As the Head of one *puskesmas* explained:

> *"…as a technical health organisation, we are directed by the DHO. We provide health services to the community and IDPs such as essential services and referral service"* (Head of Bunten Barat *Puskesmas*).

Sub-theme 6.6.2 Fees for Services

Health facilities in Indonesia have introduced formal systems of user fees for health services and the amount charged varies depending on the local government's policy. This research found one source of budget for health services in the *puskesmas* came from fees paid by the community for health service delivery. As the Head of one *puskesmas* stated:

> *"…we charge every patient Rp 5,000 for fee of service that include the health consultation and drugs and refer to the fee for service table from local government… and every month the money was sent to the MHO"* (Head of Bengkol *Puskesmas)*

It was confirmed by the Head of MHO that the fee from the puskesmas was handed to the local government According to the Head of MHO:

> *"…the fees for health services are passed to the local government office as municipal revenue. Although the money was returned to us we have to wait 2- 3 months to have it. From 100% budget from fee sources, 70% of the amount is returned and applied directly to the puskesmas's operating costs. The remaining 30% is distributed to the various health centres, not in cash but in medical supplies." (*Head of Manado MHO*).*

There were also other budget sources to the puskesmas but only for buying syringe to use to the patient. As a Head of *puskesmas* illustrated:

> *"…where a disease requires treatment by injection we charge patients for the syringes. The money is used to buy other syringes"* (Head of Bengkol *Puskesmas*).

The Head of Bunten Barat gave the same explanation as his colleague in Bengkol:

> *"…the additional fee is to purchase the injection syringe" (*Head of Bunten Barat *Puskesmas*).

In Sampang the revenues generated from patients was similar to Manado. As one of Head of puskesmas stated:

> *"…for fee of health services that includes consultation and drugs we charge Rp 5, 000 and at the end of the month we send the total fees to the DHO" (*Head of Bengkol *Puskesmas).*

According to Head of MHO Manado and Head of DHO Sampang, other revenue sources for the puskesmas included

> *"...medical payments from health insurance, including health insurance for government officials and a contribution from the integrated health programme from the Bureau of Family Planning" (*Head of Manado MHO*).*

Sub-theme 6.6.3 Service Management

Organisation of health programmes and services in the *puskesmas* were developed according to the *puskesmas*' manual which also refers to the Minimum Service Standards (MSS) developed at the central level which covers a variety of services, providing performance indicators on essential health programmes and services.

There was a problem relating to the complexity of the recommended methods of MSS in both field areas. In Manado, as the Head of one *puskesmas* illustrated:

> *"…several items in MSS specify the target that the puskesmas had to achieve, but taking into consideration the condition of the community and the environment of the catchment area this target was not achievable"* (Head of Bengkol *Puskesmas*).

The health programmes and services to the IDPs had been integrated with those for the local community. As the Head of Bengkol *Puskesmas* commented:

> *"…we integrated the health programmes and services for IDPs with the local community's health programmes and services based on the instruction from MHO"* (Head of Bengkol *Puskesmas).*

This research indicated that the organisation of the health programmes and services provided by the puskesmas might not have been working well because of their dependence on the guidelines from central level. For example the MSS might not make allowance for local situations; that is, the difference of the target population, the local environment and the topography of every municipality and district.

In Sampang, organisation of health programmes and services in *puskesmas* for IDPs was under control of the DHO and there were no specific health services provided for them. The organisation of health services for IDPs was part of the health services for the local community.

As part of the sub-district government, the organisation of the health programmes and services at *puskesmas* level was integrated with the sub-district's programmes as a whole. For example, health programmes were integrated with those of other public sectors provided for the local community and the IDPs such as education and public works. These sectors support health promotion, the infrastructure of water supplies and sanitation programmes at the barracks compound. However, some programmes were not the priority of the *puskesmas*. As Head of one *puskesmas* commented:

> *"…although some health programmes and services are integrated with other sectors, we have to follow the MSS provided by the central level, where some of the MSS items were not in our heath programmes and services delivery priorities" (*Head of Bringkoning *Puskesmas*).

The *puskesmas* level had faced problems concerning the capacity and workload of the staff in delivering health services ever since the IDPs had come to live in this district. As the Head of one *puskesmas* commented:

> *"…because the numbers of health staff in puskesmas are limited, some of the staff, particularly the nurses, are responsible for several tasks, such as health administrator, field immuniser, paramedic and midwife" (*Head of Bunten Barat *Puskesmas).*

In Manado, patients whose diseases could not be handled by the *puskesmas*, were referred to the higher level of services at the provincial health hospital. A Head of *puskesmas* stated:

> *"…patients with severe illness we'll refer to the hospital with a letter of reference"* (Head of Bengkol *Puskesmas*).

This research found that there was no protocol of referral in terms of referring the patient to the hospital.

In Sampang a similar referral system was conducted. As the Head of *Puskesmas* stated:

> *"…if we cannot handle illness from the community or IDPs we'll send them to Sampang Hospital to get advanced treatment"* (Head of Ketapang *Puskesmas*).

There was no referral system established in this puskesmas. Patients who needed advanced treatment were sent to the district hospital after obtaining basic medical services.

Theme 6.7 Local Political Situation

During the period of the research, an election campaign for the central, provincial and local representatives was held across the country. In Manado, during the data collection, the political parties' campaign for the parliaments had begun. The health programmes for IDPs ran for only short periods of time and the local political situation did not disrupt them. As the Head of MHO commented:

> *"…because of the country's political situation the programmes for IDPs were being provided in the short term. With the imminent election of members of parliaments and the president, we considered the IDPs would return to their homeland. We were also integrating our health system into our health development plans and, on the whole, the political situation in this area didn't affect the health programmes and services to IDPs"* (Head of Manado MHO).

Similarly in Sampang, the election campaign for the central, provincial and local representatives did not influence the health programmes and services for the local community and IDPs. However, there was an election of the Head of Sampang District where the result was contested and created conflict among the local elite. The situation affected the local health authority's support of health programmes and services for IDPs, including the implementation of health decentralisation policy. As the Head of DHO commented:

> *"…for more than six months the health programmes have not been well delivered to the community or the IDPs, because of the disputed local political situation. This meant that there was no inaugurated Head of the District, which resulted in some health policies, such as the health budget policy from local government, being postponed"* (Head of Sampang DHO).

Conclusion

This chapter has explored the existing local health system providing health services to IDPs at the time of the research, including the impact of their arrival and the effect of their extended stay in Manado Municipality and Sampang District, also the general effect of the health decentralisation policy. It has focused on the public sector health providers i.e. Manado MHO and Sampang DHO, as the programme planners, and the lower levels of the organization, the *puskesmas* as providers of the services.

The importance of coordination between the MHO and DHO and the different tiers of the health system have been identified as an essential part of providing health services to the IDPs. These other tiers were seen to influence the MHO's and DHO's policies, decisions and implementation of the health programmes and services to the community, most particularly to the IDPs. This was because the M/DHO, in terms of policies and guidelines, depended heavily on the central level. In addition, the M/DHO was also part of the local government's structural organisation where the local government policies had to accommodate and integrate with the central level's policies.

Although the role of other sectors, donor agencies and NGOs in the health services was acknowledged, the integration and coordination with the other development partners remained weak in both areas. Lack of coordination between the MHO, DHO and the other parties related to health contributed to the weakness of the system.

It was found that there was a difference in the health systems of the two field areas. The arrival of the IDPs placed an extra burden on the health system in both areas, but Sampang District experienced particular difficulty in handling this, although in terms of health facilities and equipments in *puskesmas* it was better than Manado. The scarcity of health workers who were competent in their expertise and the commitment of health workers particularly the doctors to work in the *puskesmas* and DHO contribute to the burden on the health system. This was aggravated by the poor economy and political situation of the district. This situation influenced the ability of the DHO to provide health services to the IDPs, although the funding support from central government was sufficient.

In the organisation of both municipality and district, the role of the M/DHO is seen as a technical department for local government organisation that is fully responsible for health issues relating to the whole population in the catchment area, including the IDPs. This research found the role of the central level was dominant in handling the health issues in these two areas. However, the health services delivery was provided by the *puskesmas* under direction from the M/DHO. At the time of the research the MHO and DHO had merged their health programmes and services for IDPs with the local health programmes and services. In addition, there was no free health service delivery available to the IDPs in either the municipality or the district.

During the survey, it was hard to assess the progress of the implementation of the health decentralisation policy in the Municipality and District since the policy had been launched in 2001 and revised in 2003. This municipality and district had just started to implement the revised health decentralisation policy, and their problems were exacerbated by the complexity of IDP issues. The implementation of the decentralisation health policy had been commenced by the MHO and DHO because it was not only a local political commitment, but also a national one.

This research was not able to determine whether decentralisation had achieved its objectives, because the progress of implementing health decentralisation policy was slow. Factors contributing to this were found mainly in administration and readiness at local level.

This research found that the readiness of the MHO and DHO to deal with the health issues posed by the IDPs was not structured according to the principles of the health decentralisation policy. This was aggravated by the lack of health resources particularly in the knowledge and skills of the human workforce and the political situation in both field areas, particularly in Sampang District. However, willingness and efforts of the M/DHO to implement the health decentralisation policy was apparent.
Discussion follows in the next chapter.

Chapter Seven

Discussion

Introduction

This chapter reflects upon the research findings presented in Chapters Five and Six in an endeavour to answer the research questions outlined in the introductory chapter. One of the main aims is to consider first of all the gap between the health needs of IDPs and the desire of the public health institutions to provide better health services.

This gap can be characterised through a focus on needs, demand and supply as explained in Chapter Three. Exploration and understanding of the health needs of IDPs will help to understand the weakness of the health programmes and services of the public health sector in the recipient areas.

Local health systems set up by the MHO and DOH in the municipality and district had made efforts to fulfill the health service delivery with fair treatment to both the local community and the IDPs, and to meet the health expectations of the population, especially to those who were in particular need.

When the decentralisation health policy was put into the local health systems in order to develop programmes and provide health services in 2001, the readiness of the local levels in terms of handling the management and the availability of health resources, and the knowledge and skills of local health workforces who were taking responsibility for the health programmes and services were considerably tested.

This chapter discusses the findings, supported by literature, and addresses the critical questions that arose during the research process; it also contrasts the issues that challenged Manado Municipality as an urban area with those of Sampang District as a poor rural area, in dealing with the health problems of the IDPs in the context of health decentralisation in the health services.

The discussion focuses on five key areas:

1) the health needs of the IDPs in the recipient areas

The IDPs who lived in different types of temporary accommodation for a period of years faced risk factors to their health that potentially increased their health needs. For example, the environment and the condition of the temporary accommodation did not support health, as they were not well maintained. Living in poor conditions with psychosocial trauma increased psychological and physical health needs and as a result increased the IDPs' demands on the health care available in the recipient areas.

The way in which IDPs coped with illness and used their recipient areas' health services was also studied. These were important in order to answer the research questions.

(2) the IDPs' experience of the health programmes and health services in the recipient areas

IDPs experiences in seeking health programmes and services, their experience of access and utilisation, and level of satisfaction with health services, including those provided by local health authorities in the recipient areas, are considered as evidence in this research and constitute a basis for development of recommendations.

(3) the experience of M/DHO in developing and providing health programmes and services to meet the health needs of IDPs

The arrival and extended stay of the IDPs in the recipient areas constituted a challenge to the local health authorities. Limited health resources, and also the characteristics and local political situation in recipient areas, created additional problems for the local health authorities. In spite of these difficulties, the public health authorities had to respond to and address the health needs of the IDPs. Their experiences in handling this difficult new situation provided valuable information for future development of health programmes and services for IDPs.

(4) public health sector responsibilities in the recipient areas in addressing IDPs' health needs in the context of decentralisation

The commitment of the Government of Indonesia to the decentralisation policy, particularly that of the Ministry of Health in implementating the health decentralisation policy across the nation, had an impact on the health system particularly on local health systems, and their programmes and services to their communities as well as IDPs. It is important to understand the responsibilities of local health authorities in terms of their commitment to the health decentralisation policy.

As previously local health authorities had relied on the resources of central level to develop and provide health services to their communities, decentralisation found them unprepared for the extra responsibility, and therefore they found the added tasks arduous. Also, for political reasons, the central level was not entirely willing to devolve control completely.

Prioritisation, implementation and co-ordination of service provision had to be considered in relation to the M/DHO response to the health issues of IDPs and its attempts to improve health programmes and services for them.

(5) challenges to and limitations of the research

While this research was intended to benefit the health system in the future, challenges and limitations were encountered in pursuing it. Many of these were associated with decisions taken in the planning period, the time available for field work, the allocated budget, local culture and sample size.

7.1 The Health Needs of the IDPs in the Recipient Areas

In Chapter Two, it was shown that conflict such as ethno-religious and political conflict can result from a wide range of factors, including competition for scarce resources and political power; government transmigration programmes; and dissatisfaction or desperation on the part of marginalized groups. These have consequences and impact particularly on people who suffer conflict. In 1999 and 2001, ethno-religious conflicts caused savagery, destruction, suspicion and a complete breakdown in trust within some

Indonesian communities, resulting in a decrease in health status, increasing the needs of the people.

The researcher realised that health needs assessment is not simple, because such need can be varied and cover a wide range of issues in an individual's life, including factors that contribute to health needs. However, this research was conducted as previously explained in Chapter Four (Methodology) in order to approach and explore in detail the health needs of IDPs who lived in the recipient areas.

Health needs, as discussed earlier, are defined for the purposes of this study as felt or perceived needs. This research found various factors contributing to an increase in the health needs of IDPs. For example, IDPs are known to be vulnerable to serious outbreaks of communicable diseases. In the two field areas communicable diseases such as malaria and diarrhoea, were the main cause of illness and were particularly high among adults. In Sampang communicable diseases also affected children under five years old. In addition, among the adults, there were a number of non-communicable diseases such as hypertension, stroke and cancer.

The official health profile of Manado indicated that diseases such as acute respiratory infections, diarrhoea, malaria, dengue hemorrhagic fever and tuberculosis were frequent in this area (Dinkes Manado, 2003). In Sampang, the Dinkes Sampang report (2003) revealed a similar profile with diseases such as leprosy, tuberculosis, diarrhoea, malaria and typhoid as frequent in this district. These common diseases must be taken into account because the IDPs live in both areas and potential transmission is possible.

This research failed to identify serious psychological problems among the IDPs although this was raised during the FGD in both field areas. This contrasts with the findings of other researchers. In Manado, for example, Irmansyah and colleagues found that "some of IDPs experienced traumatic events directly during the conflict. The IDPs saw the event directly, especially their own family members being injured and killed, became easily angered, worried, and experienced shock. They also became irritable, more quiet/daydreaming, and cried easily when remembering the story" (Irmansyah *et al.*,

2001: 7). The IDPs were likely to keep their stories to themselves and avoid events that could remind them of their experiences. A WFP report (2000a) indicated that, physically, they reported tachycardia, stomach-ache, insomnia, low appetite, headache and difficulty with concentration. A study in Sampang by the WFP revealed that "traumatic events experienced by the IDPs were marked by symptoms such as day dreaming, sadness, insomnia, nightmares, increase in heartbeat and suicidal feelings" (WFP, 2002b: 56). The IDPs suffered psycho-trauma due to the conflicts that exacerbated their decline in health status (Irmansyah *et al*., 2001). This research found respondents mentioned only the minor symptoms of psycho-trauma, such as headache and insomnia. The passage of a few years since these previous studies may have blunted the impact of incidents during the conflict. However, as it has been found that they suppress past traumatic experiences, the effect of this suppression might influence their health needs in the future.

An earlier study by Irmansyah and colleagues in the same place revealed that "some IDPs reported deaths due to persons affected by stress refusing to eat and drink. Some deaths among the IDPs, particularly those of the elderly, were caused by a disease that they already had earlier. Often the family did not know the cause of death because it had not been diagnosed by a health worker. There were no reports of murder or attempted suicide" (Irmansyah *et al*., 2001: 7). This research in 2004 found no reports of the most extreme effects of stress resulting in death.

Mortality is a further indicator of health status and can be high among displaced people because of their experiences. In Manado, during the period the survey was conducted, a small number of deaths were reported by the IDPs. Non-communicable diseases contributed significantly to these causes of death. In Sampang, although some deaths were due to non-communicable diseases, the main causes of death (for example diarrhoea, tuberculosis and pneumonia) were communicable diseases. Although these were small numbers, the argument that communicable disease is more important in this context refers to the causes of illness found in this research that had the potential to cause death. The health profile of Sampang indicated that the factors contributing to the

incidence of communicable disease were the poor sanitation of the temporary accommodation and the lack of clean water that allowed them to spread.

The health status of IDPs in two field areas was influenced by various factors and the descriptive statistical method was applied for certain factors that might have contributed to or influenced it. Among the factors considered were the type of temporary accommodation and place of household allocation; certain determinants of health; characteristics of household respondents and the essential health services (MCH, family planning, immunisation, nutrition, environmental health and basic medical treatment) offered by the public health sectors.

All the following conclusions are affected by the inadequate sample size used for the survey, and should therefore be treated with caution.

The research suggested that in Manado, although the condition of the temporary accommodation was well situated and some of it was well maintained, the percentage of illness was increased if the numbers in a household were large. A similar situation was found in Sampang the large numbers of the IDPs in on household were potential increased the percentage of illness of the members.

Education is considered to be a determinant of health. The knowledge and skills attained through education may shape a person's cognitive functioning, make them more receptive to health education messages (Lee *et al*, 2003), or more able to communicate with and access appropriate health services available in the recipient areas. Therefore it could be expected that a higher level of education would result in better health. However, the educational level of IDPs who lived in these two areas appeared to have had no significant effect on their health status. This research suggested that IDPs with different educational backgrounds were equally likely to suffer from the same illnesses.

Occupation is another determinant of health. Unemployment is generally considered to be detrimental to health (Colin and Schofield, 1998). In Manado those IDPs with uncertain employment had poorer health compared to those with settled occupations or

those who were unemployed. In Sampang things were different, respondents with a job had poorer health than those with uncertain or no employment. This illustrates that single determinants considered in isolation can be misleading and other factors have an influence.

Many IDPs in both Manado and Sampang had lived there for more than three years. Those who had lived in Manado for a shorter period had more illness than those who had lived there longer; whereas in Sampang the opposite was true. The effect of the length of stay therefore seemed to depend on the area in which the IDPs lived and can be related, among other factors, to the climate and the standard of accommodation.
The IDPs in Sampang District were living in highly distressing conditions with poor infrastructure which contributed to the re-emergence of many infectious diseases. The researcher observed that the barracks were in a damaged condition due to a previous natural disaster and all the temporary accommodation was run-down and suffering from a lack of maintenance. This situation contributed to their poor health status.

Water is essential to all living beings and the quality of drinking-water is important for the health of a community, which could be threatened if the water becomes contaminated with infectious agents or toxic chemicals. In both field areas the water for drinking presented no health risks. However, access to drinking water was difficult for some who lived in Sampang as they had to walk quite far in order to obtain it. This condition created another burden for these IDPs.

Another area of concern was environmental health. Sanitation, or lack of it, can have significant effects on health (Bartram *et al*, 2005). In the absence of basic sanitation a number of major diseases could be transmitted to both the IDPs and the local community through faecal pollution. In addition, poor hygiene habits, and the poor condition or non-existence of latrines, coupled with overcrowded accommodation, could contribute to a high incidence of water-borne and sanitation related diseases. Sanitation in relation to health and hygiene is the primary cause of most of the infectious diseases, which have the potential to result in high morbidity and mortality (WHO, 2006a). In Sampang

District there was a problem due to inadequate sanitation, unsafe disposal of human excreta. Open defecation in the fields, particularly by the IDPs who lived in houses built on relatives' land in certain places was common, especially for those who lived in the surrounding woods. Their acceptance of this situation indicated that such habits were not uncommon in their original place, where geographical conditions were different e.g. villages situated on a river or by the seashore.
During the period of research no outbreak of water borne or sanitation related disease was reported, but it was obviously an unsatisfactory state of affairs from the public health perspective.

Another environmental health problem in this district was a lack of management of household waste. The researcher observed a large amount of household waste scattered around the temporary accommodation, predominantly in the barracks, because the pits for disposal were already full and confirmed that there was no system of collection and treatment of the waste. As might be expected, this led to infestations of flies, the presence of rats and an unpleasant smell in the surrounding compound. All these presented a health hazard and were a source of concern to the IDPs, but they considered it a matter for the authorities and not something that they could control although they had dug a few pits themselves. The IDPs felt discouraged as the local authorities did little to resolve the problem. This apparent lack of concern about household waste is yet another example of lack of cooperation/coordination between different sectors of the local authorities.
These IDPs were at considerable risk of contracting a variety of health problems, in addition to being exposed to new climatic and environmental conditions in the recipient areas. The complexity of these conditions affected the health status of the IDPs.

There was little concern expressed by either health authorities or IDPs in either field area regarding the sanitation and associated issues affecting the health status of the IDPs. The M/DHO and related cross sectors in the municipality and district were responsible for handling environmental health problems and lack of coordination by these health authorities with the other sectors had led to this situation.

Living conditions of IDP families in temporary housing units in Sampang did not all meet basic standards, and it was possible that disease caused by lack of sanitation would have appeared. In Manado, although the IDPs were in temporary accommodation, they lived in brick houses and one large building, all with sufficient public infrastructure. They were relatively privileged compared to the IDPs in Sampang. However, the living conditions of many IDPs remain undignified and continue to demand proper response.

IDPs may often be resettled in temporary locations with existing high population densities. In these two field areas the IDPs in Manado, particularly those in Kitawaya, lived in the middle of a local community. IDPs in Sampang, particularly those who lived in barracks in Ketapang sub-district, also lived close to the local community. Such situations can create tension and social conflict between the displaced and the local people (iDMC, 2006b) especially if the areas are already impoverished as in Sampang. In addition, IDPs vying with the host communities for low skilled jobs can force down already low wages (Waldman, 2001). These views affect all aspects of cooperation between the two groups, including the provision and access to health services. An existing community may feel that the incomers are being favoured, that their own interests are being overlooked or that local health services are becoming overstretched to the detriment of all. In addition, tension with the local people could hinder IDPs accessing the health facilities, particularly where the locals barricaded the road to the public services.

Many of the IDPs in the research areas were poor and economically marginalized, as their skills, which were mostly farming or fishing-based in their homeland, were not easily transferred to the new places. This then placed constraints on their access to basic necessities such as food. However, in the areas studied hunger was not present because of agency support up until 2003 and subsequently most of the respondents had been able to find enough to eat. Populations affected by food scarcity are susceptible to disease, with potential public health consequences, but during the period of study in Indonesia this did not appear to have happened.

The complexity of their situation in exile influenced the IDPs' health and made them more susceptible to the diseases that potentially increased their health needs. These health needs were not expressed as demands because they were uncertain of what they needed regarding health services. They recognized their health problems, but did not always know how to handle them and sometimes just ignored them.

7.2 The IDPs' Experience of the Health Programmes and Health Services in the Recipient Areas

IDPs did have a number of ways of coping with their health problems. In both recipient areas their decisions regarding health care varied and depended on the severity of the diseases. They recognized and looked for a range of health services available in their areas at all stages of their illness. However, postponing visiting the health facilities or looking for alternative methods to cope with illness were both found in this research.

It was normal behaviour, particularly for those who were poorest, to delay seeking health service help until it was clear that it was necessary. They tended to consult those within their own community who were perceived to have health skills. Use of traditional healers and spiritual healing may assist them in coping with diseases and stress as this is familiar behaviour from their past lives and may give comfort and so assist recovery.

During the time the IDPs lived in the two field research areas, a number of plausible factors associated with the use of services in response to their health needs emerged. Discussion of the health experiences of the IDPs in the following section is focused on access to and utilisation of health services and facilities and their satisfaction with the health services provided by local health authorities

7.2.1 Access to and Utilisation of the Health Programmes and Services

According to Wadhwa "access to health services can have positive effects on health services outcomes, for example by providing convenient, culturally sensitive programmes in essential health programmes" (Wadhwa, 2002: 4). Better access depends on a wide range of factors – distance between the health facilities and temporary

accommodation, and the economy and culture of the IDPs. Of particular relevance to the level of access and utilisation of health services were the health systems and policies of the local health authorities in terms of strategies and plans that prioritised health needs, and resource requirements. As Pavignani and Colombo (2005:1) stated: "utilisation of health facilities for services is frequently adopted as a proxy measure of access".

This research found Manado, as a city, offered easier access to health facilities compared to Sampang. Cities constitute opportunities for improving access of the population to health services (Wyss, 2003: 7); however, *puskesmas* in Manado did not have such good facilities particularly in terms of health equipments, laboratory and mobile *puskesmas* as those in Sampang.

SDC (2003) revealed that "there is no universal explanation for health access that applies across different settings; the determinants of access are not the same across cultural, socio-economic and political contexts" (SDC, 2003: 1). Manado and Sampang were different in terms of characteristics such as social, political, administrative, geographical, economic, local education and cultural factors. These influenced access to and utilisation of health services for IDPs.

This research found the following factors influenced access to and utilisation of the Health Programmes and Services:

i. Treatment costs including indirect financial costs

With the change in IDP status following the government's 2003 decision, this research found that IDPs were expected to pay fees for health services, which previously they had received without payment. In addition, IDPs had to pay the cost of transportation and for drugs from the pharmacy. It meant that people were compelled to pay when they sought care from modern health services, as the local population already had to.

Financial constraints affected all the IDPs, but poor families living in remote areas had most difficulty. Sick IDPs depended more often on self-treatment, and rarely consulted public or private health services. As there was no public budget for health services for IDPs, fees affected utilisation of health facilities. Because of the vulnerable socio-economic condition of IDPs in the two field areas, they faced new difficulties in accessing existing health services in the recipient areas. As one respondent commented "…*sometimes we just ignore the disease because we don't have enough money to buy the drugs*"

Another reason was that, in relation to childbirth, the financial cost of delivery was likely to be less for the traditional attendants than the hospital. This research found that the TBAs charged no fee but instead were given a gift as an expression of thanks that was commensurate with the financial status of the household.

ii. Cultural barriers

Cultural perceptions influence and can constrain use of health services. The culture of the IDPs was an influence in their use of the health services offered by the public sector. In relation to pregnancy and childbirth, the IDPs in both areas preferred to be helped by TBAs at delivery rather than using health facilities, even though they used the ANC and PNC programmes offered by *puskesmas* to monitor their pregnancy and post partum period. The service offered by the TBAs was relatively free of charge and the pregnant women felt comfortable delivering with their help even in the temporary accommodation.

Pregnant IDP women in Manado and Sampang used the provision of basic antenatal services provided by the public sector. However they did not consider postnatal care to be of importance and therefore some chose not to attend the health facilities for that. Women were less likely to attend for delivery, which meant they did not receive information about warning signs of complications, and there was less opportunity for timely referral by the health workers to more advanced facilities. Generally the health worker was only called to assist at a birth after it had become clear that the case was too difficult for the TBA to manage.

Immunisation programmes were widely available to the IDPs. However, there were still infants who were not immunised because of the parents' beliefs. For example an IDP respondent in Manado stated that babies who are under six months old should not be given injections.

iii. Weak communication between health providers and the IDPs

In health facilities pressure of patient numbers, lack of time on the part of the staff and a more formal atmosphere made communication difficult. This was resented by the IDP, who complained about it to the researcher.

Poor communication with the health workers who gave them treatment influenced their utilisation of health facilities.

iv. Security and interaction between IDPs and local community

Social aspects of the life of IDPs, including interaction between them and the local community, were important regarding the security of IDPs and their access to health facilities. In Manado, a dispute existed between the local community and the government about the land occupied by the IDPs and this resulted in conflict with the local community. In Sampang, there was conflict between the local community and IDPs. This situation made it difficult for the IDPs to integrate with the local community. Fighting between IDPs and their local community could deny the IDPs access to the public facilities including, for example, when the locals block the road to the health facilities resulting hindering the access of the IDPs to obtain health services.

v. Geography and topography

In Manado, this did not limit access to health facilities. An attempt was made by the MHO to improve accessibility by providing a new *puskesmas pembantu (pustu)* or auxiliary health centre in the temporary accommodation area in the compound of the brick houses. In Sampang, many IDPs stated during interviews that they found accessing the health facilities difficult, especially those who lived in remote areas. They had to walk for some kilometres to reach the health facilities. Increased distance between the

temporary accommodation and health facilities decreased the utilisation of health services.

In both field areas, utilisation of health services depended on the severity of illness and the person who suffered from the disease. Infants and children, for example, were taken directly to the health facilities.

7.2.2 Satisfaction with the Health Services

Patient satisfaction is a component of health service quality (Jenkinson *et al.*, 2002). Expectations about the quality of health services are linked to perceptions of care, and when patients' perceptions are positive their clinical experience and outcomes are more likely to be positive (Kenagy *et al.*, 1999).

Assessment of IDPs' satisfaction with the public health services provided in the recipient areas was difficult on the basis of the replies to relevant questions, but it could be interpreted as "fairly satisfied". During the survey the respondents felt uncomfortable about explaining clearly what they thought about the health service they received from local health authorities. In addition, the IDPs had little choice of health services, particularly those who lived in Sampang District where the health service was dominated by the public health sector.

This research found that the IDPs' perception of the satisfaction of their health needs by provision of health services was almost similar in Manado and Sampang. Satisfaction with health services obviously varied according to the individual and the nature of the service. In Manado, the IDPs had some complaints, but not really about the health service provision by the public health sector, although prescription of similar drugs for different kinds of illness was still a big concern. In Sampang, there were no complaints from IDPs about the methods by which health services handled cases or of the means by which the health workers delivered the health services in the health facilities. However, there was criticism about being treated with similar drugs for differing symptoms, particularly in the *puskesmas*.

IDPs satisfaction, particularly of those who receive the services, is an important determinant of the health service provision by the public sector. It includes how the services were perceived by the IDPs with regard to the health workers (nurses and doctors). Although overall satisfaction was expressed, this research found the respondents in both field areas were dissatisfied with some aspects of the services that they had received in the health facilities.

Satisfaction with health services varied according to the individual and the nature of the service. The degree of satisfaction with health services of the respondents in Sampang District was similar to that in Manado.

Gauging satisfaction for health services provided by the public health sector is not easy because of the different experiences and opinions of the respondents, especially if the respondents are hiding their dissatisfaction because they consider it impolite to criticise authority. IDPs satisfaction, particularly of those who receive the services, is an important measure, however, of the adequacy and quality of health service utilisation provided by the public sector and might be investigated by the providers. At the time of this research no mechanism for gauging patient satisfaction existed.

Over all, access to and utilisation of health services by IDPs in both field areas was influenced by the cost of the treatment and indirect costs, the culture of the IDPs, communication with health providers, security and interaction between the IDPs and the local people, geography and topography.

7.3 The Experience of M/DHO in Developing and Providing Health Programmes and Services to Meet the Health Needs of IDPs

The impact of conflict in Indonesia has not only created IDPs and devastated their home areas, but also affected the areas that received them. This research found that the arrival of the IDPs in both recipient areas had affected the local health systems. Manado MHO and Sampang DHO, as the responsible institutions for the health of IDPs, were challenged to develop health programmes and provide services to them, this included how to prioritise, implement, co-ordinate service provision.

The challenges for the M/DHO increased greatly when the IDPs decided to prolong their stay in the recipient areas. In addition, at the end of 2003, the Indonesian government declared that there were now 'no IDPs' in the country. However, many displaced persons remained. The result of this declaration meant limited central support available (withdrawal of some support such as human resources) for local authorities including health. This meant that health programme planning, organisation and delivery for the former IDPs were incorporated with that of the local community. The M/DHO had to extend health programmes and services to make health resources available for both groups.

7.3.1 Management of Health Programmes and Services for IDPs

The management processes in health programmes and services such as planning, implementing and monitoring and evaluation provided for IDPs by the M/DHO were important elements of the health system. Palmer (1998) suggests that health providers often underestimate the significance of health programmes to the IDPs with whom they work. This may be because specific needs assessments where appropriate questions were asked were not undertaken, thus perpetuating the perception that there was a lack of demand for such services.

This research found that gathering relevant health information in order to get a picture of the health situation of the IDPs posed a particular challenge for both M/DHO in planning and implementation. In setting up health plans, these two institutions gathered health information from *puskesmas* as well as hospitals. They continued to rely on previous plans rather than seeking fresh information about the circumstances of different population groups, such as IDPs. There was a lack of ability by the health programme holders in analysing the results of the monitoring and evaluation, including giving limited or no feedback to the *puskesmas*. In addition, monitoring and evaluation was not a strong feature of the health programmes and services for IDPs designed by the M/DHO. Their approach to it was to hold regular meetings with *puskesmas* which were limited to reporting the progress of the health programmes and services that referred to the Minimum Service Standards (MSS). The MSS developed by central level was too

general in terms of developing, implementing, monitoring and evaluation of health programmes and services for the whole country, without focus on the particular health issues posed by municipalities and districts. Indeed, their form of monitoring and evaluation emphasised monitoring rather than impact evaluation. This condition hindered the planning and implementation of the health programmes for the IDPs.

The MHO and DHO extended the health programmes and services available to the local community to the IDPs without revising existing health priorities. There was a lack of innovation by the MHO and DHO in creating guidelines for health programmes and services for the IDPs. This situation was due to the previous high dependency on central level guidelines, although local data were available for planning health programmes and services. As this research found, some of the policies for health programmes that came from central level were not suited to the local health situation. Health programme priorities from central level were not always compatible with the issues at the local level. For example, target coverage of certain programmes was considered by central level to be maximum percent coverage without considering the capacity of health resources and topography at the local level.

Reliance on the guidelines from central level made it difficult to explore in detail the specific local health issues that challenged the planning and implementation of the health programmes. This situation did not allow for the specific health issues presented by the IDPs.

At the puskesmas level, the number of *puskesmas* within the municipality and district health systems was determined on the basis of the presumed workload generated by providing services to the population living in the catchment areas, including the IDPs. The status of each *puskesmas* varied in terms of availability of health services. For example, in Sampang some of *puskesmas* were providing in-patient health services, where in Manado the *puskesmas* were only providing health services for out patients. *Puskesmas* in Manado were not supported with mobile clinics or *pusling* and only one *puskesmas* had a laboratory but without an analyst. In Sampang most of the *puskesmas*

were equipped with *pusling* and there were two laboratories with analysts. However the other four *puskesmas* had no laboratories. *Puskesmas* in both areas suffered from a shortage of certain drugs and medical supplies.
Lack of support for health facilities and experts, in this case laboratory analysts, particularly in Manado, had a direct impact on the performance of health development and in providing health services to the local community as well as the IDPs.

The responsibility of the health officers in the MHO, DHO and *puskesmas* was enlarged due to their added workload in managing, developing and providing health programmes and health services to the IDPs beginning with their arrival and continuing with their extended stay. They did not all have the experience or skills necessary for handling it and expressed their need for training and short courses. Their difficulties were compounded by the introduction of decentralisation.

Puskesmas in Manado were not supported with complete basic health facilities. Although Sampang was a poor district, *puskesmas* in Sampang were better supported with health facilities than Manado.

7.3.2 Health Referral System

Referral in this research is a process by which a health worker in a *puskesmas* transfers the responsibility of care temporarily or permanently to a hospital. The *puskesmas* are supposed to be the first point of health service contact for IDPs. Patients are then referred from the *puskesmas* to the hospital. Health referral systems in Manado and Sampang were different in terms of the level of service of the hospital to which the patient was referred. In Manado, the referral hospital provided more comprehensive health services compared to that in Sampang District. This study also found that, in terms of public infrastructures such as roads and availability of transportation, which is an important factor for referral systems, Manado was more developed than Sampang.

Problems faced by the *puskesmas* in Manado in referring patients to the hospital were thus minimal compared to the problems encountered by the *puskesmas* in Sampang. In

Sampang, distance and transportation were the significant issues for the referral system. Those IDPs who lived in the three sub-districts of Ketapang, Banyuates and Robatal faced problems of distance and transportation to the district hospital. In addition, financial support for the operational cost in order to refer the patient to the district hospital was constrained. This situation made it difficult for the *puskesmas* in Sampang to refer patients to the district hospital.

7.3.3 Long Term Health Programmes and Services to IDPs.

When in December 2003 the Indonesian government declared an end to the IDP crisis in all the provinces that had received them, it left the MHO/DHO with a confused situation i.e. they still had IDPs, although the government stated that there was no longer any need for extra programmes. Cessation of central level's policy/responsibility left local recipient areas with no planning or resource guidelines/sources.

Given the difficult situation in the recipient areas such as employment competition and problems in social interaction with the local community, many of the IDPs intended to return to their home areas. However for various reasons, many were unlikely to be able to return to their respective places of origin, although this study found they were willing to return. Despite there being a programme created by the central government and supported by local governments and NGOs for returning IDPs to their homeland, the local government in Manado and Sampang had no information on the IDPs' long term plans on whether they wanted to return to their original places or to settle in the recipient areas, so effective plans could not be made for long term health programmes and services.

Moreover, according to iDMC (2006) the current handling of the IDP problem has become more complex as it is not only a humanitarian concern but is linked to political, social, cultural, religious and security affairs. The longer the IDP problem remains unsolved, the more complex it will become, and in the end, will threaten the government process and national development. The long stay of IDPs in recipient areas may also

create jealousy and dissatisfaction between them and their local communities because locally owned land was occupied by the IDPs.

A critical issue of this research was the absence of reliable information on health programmes and services to the IDPs. The existing health programmes and services had been extended to cover the health needs of the IDPs through integration with the local community health programmes and services.

This research found there was no medium (2 – 3 years) or long (5 years) term health programmes and services planned by the local health authorities for the remaining IDPs who still intended to return home at an undetermined time in the future.
Those who had decided to settle permanently in the recipient areas were now considered by the health authorities as part of the local community, were treated as such and no longer considered to be IDPs.

7.3.4 Local Political and Economic Influence on Developing Health Programmes and Services for IDPs

This research found that the unstable political situation, particularly in Sampang District, indirectly influenced the health service process for both the local community and IDPs. The delayed new election of the Head of District affected the implementation of health programmes. Approval of financial support for health from local resources had to wait for the executive's approval. This situation extended the delay in financial support from local resources for health activities in that district.

The relationship between the local economy and the health of IDPs is one of the most important issues in the ongoing health decentralisation policy. Since the arrival of the IDPs in the recipient areas the health status of the IDPs had been the concern of the local health authorities and their efforts to fulfil the health needs of the IDPs was dependent on the economic conditions in the municipality and district. In other words the economy of the recipient areas influenced the provision of health services. The economy in Sampang District, in particular, was poverty stricken; being the poorest district in the East Java Provinces meant that the budget to support the health services was limited.

This situation resulted in less financial support from local resources to the health sector. Poverty has the potential to slow the implementation of the health decentralisation policy, because devolving power to the local level includes handing over responsibility for raising revenues to support health programmes and services.

7.4 Public Health Sector Responsibilities in the Recipient Areas in Addressing IDPs' Health Needs in the Context of Decentralisation

The policy of health decentralisation is relatively recent in Indonesia. The move from centralisation to decentralisation took place at a time when the country had been overwhelmed with complex emergency situations. As the literature review demonstrates, numerous health decentralisation concepts are offered to help countries that are ethnically diverse and multi-religious to reach a commitment to reorganise the structure, policy and service of their health sectors to serve their heterogeneous societies.

Decentralisation is an important element in developing accountability as it also enables the development of partnerships between local government and non-state actors (Fustukian, 2004). Essentially, decentralisation of the health sector is meant to be about strengthening health system performance – about improving the ability of health systems to deliver better health services and programmes that are more efficient, equitable, and responsive to local needs (WHO, 2000). The purpose of the health decentralisation policy in Indonesia was to allow the local health authorities to ascertain and respond to their municipal/district health priorities for health development.

Under this policy the MHO and DHO were granted the authority and responsibility to develop and provide health programmes and services including a referral system based on particular local needs. The decentralisation health policy also gave communities an opportunity to take responsibility and ensure that their health facilities operate smoothly.

Prior to the implementation of the health decentralisation policy in January 2001, the top-down structure in Indonesia was clearly evident. The M/DHOs relied on the uniform methods provided by central level. This situation caused the local level to be dependant on the central level. In this structure, the MoH had a very dominant role. However, after

2001 and the revision of health decentralisation policy in 2003, the administration of health programmes and services in Indonesia changed dramatically.

The progress of the health decentralisation policy in Indonesia was slower than the public expected. This situation was revealed by the study conducted by Kristiansen and Santoso that "firstly, the total lack of transparency gives the executive branch of municipal/district administration a high level of discretion and a low level of accountability, which is often misused to the disadvantage of health. Secondly, too much responsibility has suddenly been left with local institutions without education or training, and they are therefore poorly prepared for planning and implementation of new policies. Thirdly, the executive and legislative branches of district administrations, as well as the medical doctors and personnel, are too concerned about income generation" (Kristiansen and Santoso, 2006: 248). It is not a simple matter for staff who have been trained and accustomed all their working lives to take direction from central level to find that direction and support has been withdrawn. Giving local health workers greatly increased responsibility for which they did not feel prepared inevitably led to tardy progress in implementation of the health decentralisation policy.

With health decentralisation policy the management process of health programmes and services at the local level was changed. In applying health decentralisation policy, expanding the functions of the M/DHO in terms of developing health programmes and providing health services for IDPs could not be avoided. As a consequence, changing the management process had an impact on different elements of the health system. The various tasks and functions of the M/DHO and *puskesmas* were substantially reorganised to enable them to give the community and IDPs better health services. In parallel the M/DHO had to identify the key steps of the health decentralisation policy that came from central level and suit them to the local settings.

One of the main challenges to health decentralisation in Indonesia was that, while decentralisation aims to improve health system performance, its implementation relies on the capacity of the local elements. This research found that, although responsibility

for health planning had been given to the local levels, they had little authority to carry out their plans, and a lack of skilled health workers exacerbated the situation. In addition, while decentralisation aimed to clarify the health roles and responsibilities of Central, Provincial and Municipal/District government, in reality during the process of decentralisation, the role of the provincial level implementation was not clear in regard to its responsibility. The Central level had a very strong influence on health decisions at the municipal/district level through administering the law, guidelines and policies. In other words, the roles and responsibilities between central and local government were not clearly defined or in effect not sufficiently decentralised.

Moreover, the implementation of the health decentralisation policy that had just been launched in Manado and Sampang was slowed by the arrival of the IDPs. The ability of the local government to handle the IDPs' health conditions was less than competent and was aggravated by the local health situation. The local government was dependent on the central level guidelines for developing health programmes, health resources and standard coverage of the health programmes. All these factors contributed to the slow progress of health decentralisation policy. At the municipal and district level in these field areas, the decentralisation process caused negative repercussions that spilled over to the sub-district due to the following factors: (i) poor governance and participation; (ii) dependency on the central level; (iii) weakness of the M/DHO in anticipating the elements and work implication of health decentralisation policy. The critical issue of health decentralisation policy in recipient areas was the extent to which the process had impacted on the ability of the public health system to deliver services to IDPs.

This research found that restructuring the functions of staff positions and reallocation of roles and responsibilities affected the health workforce and the way it was managed in the organisational structure of the M/DHO. In addition the lack of capacity and professionalism of the health workforce contributed to the slow progress of health decentralisation.

The Decentralisation Unit (DU) at central level had the task of facilitating health decentralisation including advising local levels on operational guidelines and help to support health operations in poor regions. This included assisting local staff. This began not long before decentralisation and was not complete at the time of this research. Hardee and Smith (2000) forecast that "experience suggests that health decentralisation policy will fail in the absence of skilled staff". The health decentralisation policy in Indonesia, however, must succeed. To this end, assistance from central level in local staff development will be essential for the foreseeable future. Not every initiative will be successful in every locality and only central level receives the feedback from its workers in municipalities/districts.

This research found that the local health authorities were most willing to adopt and implement the key steps of the health decentralisation policy and the researcher considered it was increasing local accountability. However, in 2005, a review on the 4th year of decentralization in Indonesia conducted by Gajah Mada University and collaborators revealed a serious problem regarding the capacity of Ministry of Health and District Health offices to develop the Minister of Health's decree and to draw up local regulations for developing a decentralised health policy. In addition, the health decentralisation policy appeared to have had the effect of increasing central control and accountability. Central level seemed reluctant to give more power to the local level and the commitment of central government to develop decentralised regulation was low.

This research found, although it was very difficult for them to develop and provide health services to both the community and IDPs because of the above situation, essential health services for IDPs continued to be provided by the MHO, DHO and *puskesmas.* Responsibility for local health resource allocation, integration of health programmes and services for the IDPs and co-ordination of health programmes and service to the IDPs was the responsibility of the M/DHO.

7.4.1 Local Health Resource Allocation

Health resources, as a health system element, are essential for developing health programmes and providing services to achieve the targets of health programmes and services for IDPs, particularly in the setting of health decentralisation. The health workforce, drugs and medical supplies and financial support in the two field areas varied in terms of number, capacity and amount.

i. The Health Workforce

A health workforce is fundamental to functioning health programmes and services for IDPs. In both field areas, with the arrival of a large number of IDPs at the same time and their extended stay, the local health workforce had encountered new health problems for which they were not prepared. Their experience and training had not prepared them for this new situation.

This research found that the health workforce in the two areas was different in terms of numbers, qualifications and motivation. Manado Municipality had the support of a wide variety of health expertise in its workforce. In contrast, in Sampang District, there were fewer personnel and limited expertise. The situation was aggravated because some of the health workforce, particularly the doctors, was not resident near the *puskesmas.* In addition, they were motivated to work only as required by their contract with the government.

Since the IDPs' arrival in Manado and Sampang, the responsibility for their health care was laid on the MHO and DHO, although the MHO and DHO found it necessary to rely on central level support. As a result the workloads of the health workforce in both field areas increased. They had extra responsibilities in dealing with the diseases that the IDPs brought with them or acquired while they lived in temporary accommodation. The limited expertise and experience of MHO and DHO health workers in planning, monitoring and evaluation challenged the provision of adequate health programmes and services to the IDPs. As a consequence of these difficulties, lack of planning for the IDPs resulted in there being no particular health programmes and services, or even a specific health package, offered by MHO and DHO to cover their health problems.

In Manado, the health workforce was sufficient in terms of numbers, but limited in health management expertise. Here the health workforce was large, with many kinds of medical doctor ranging from general practitioners to specialists and also nurses, midwives, pharmacists and many other types of health experts. This was because Manado is the capital city of the province and the health facilities were comprehensive. However, Manado MHO was not adequately supplied with health planners, particularly those with expertise in complex emergencies. After the arrival of the IDPs and the introduction of health decentralisation, several training courses for the health workforce in management were conducted by central level. These training courses were attended by the MHO and *puskesmas* staff. The courses were drawn up quickly, in response to the situation and filled the gap at that time. However, they were limited in terms of content so could not be considered as the end of what was required. At the time of this research, the Head of Manado MHO expressed the opinion that more training was essential. As health decentralisation continues, problems will arise so training has to be an ongoing process.

In Sampang, the skilled workforce was limited with regard to medical doctors, specialists and other health professionals as well as health planners with expertise in complex emergencies. This district is a rural area and less attractive for health workers from outside to work in. In addition many health workers want to work for only the three years of their contract and then move on. The comment from one health worker "…*when my contract with the government terminates I'll move to the city and will train to specialise in surgery*" reflects the attitude of staff, which results in high turnover and shortage of personnel in this district and will affect the performance of the health services for the IDPs. The manifestations of this were obvious, such as vacant posts in several sections in the organisational structure. Sampang's DHO was limited in terms of both numbers and skills. This situation influenced the development of health programmes and provision of health services to the IDPs. There were fewer health workers with the skills to deal with IDPs' health and therefore they relied heavily on assistance from the Central and Provincial health workforces.

Again, efforts in training of the health workforce by central level were made by Sampang DHO to improve the capacity of their workforce in management of IDPs and the health decentralisation policy. However, the capacity of the health administrative system in maintaining the workforce was inadequate, not only in dealing with personnel problems in the health services, but also for ensuring the institutional capacity of the health management system and maintaining conditions that would enable personnel to meet the objectives of the health services, particularly for the IDPs. With a steady turnover in the health workforce, the need for constant training will be even greater than in Manado.

ii. Drugs, Medical Supplies and Equipment

Since the implementation of the health decentralisation policy, the responsibility for the provision of drugs to the local community and IDPs in these two field areas had been transferred to the M/DHO. This new policy increased their responsibility to select, procure and effect the distribution of drugs and medical supplies within their areas, bringing to the fore the issue of whether or not these drugs and medical supplies were being used rationally and by those who needed them most.

Provision of drugs, supplies and equipment in the municipality and the district was influenced by many factors including health workforce numbers and quality and the process of bidding. As the Heads of the MHO and DHO made clear, there was outside interference in the process. For example, the M/DHO had encountered issues in dealing with the local politicians and family members of local government officials interested in and favouring the bidding process. In this situation, there might be a potential collusion among bidders during the bidding process, which might result in reducing the quantity of drugs, medical supplies and equipment planned by the M/DHO, because the prices for certain drugs, supplies and equipment could be increased by the mark-up for the bidders.

Financial support for drugs, medical supplies and equipment was dependent on central level and local government. However, even though the drugs, medical supplies and equipment for the IDPs were supported by these two financing services, this research

found that certain essential drugs (particularly antibiotics) were of limited availability in both field research areas. This situation occurred because the drugs were expensive and the allocated budget for the expensive drugs was limited. As a result, sometimes at the end of the month, the stock of antibiotic drugs was finished. The availability of certain drugs influenced the performance of the *puskesmas* in providing health services related to basic medical treatment.

Issues in providing drugs, medical supplies and equipment for the IDPs in these two areas were very similar, including the lack of competence of the health workforce in procuring them. However, irregular release of the budget support for drugs and medical supplies resulted in there being a difference between Manado MHO and Sampang DHO in seeking the money to provide these for both the local community and IDPs. This research found that the Head of the Manado MHO displayed more initiative in terms of lobbying the local government for financial support in providing the drugs and medical supplies in the area. Positive initiatives by the local health authority in lobbying the local resources for budget could be a strong support to the health programmes and providing health service delivery to the IDPs.

This research found health support facilities were more complete in Sampang *puskesmas* than in Manado. This might have been because the availability of health services provided by the private sector was prominent and more comprehensive than that of *puskesmas* which only provided basic health services. In addition Manado as a city was easily accessible in terms of transportation to reach the public services.

iii. Financing Health Programmes and Services

Funds flow into the health sector from a variety of sources and the major sources, as the revenue of M/DHO, were described in Chapter Three. A study done by Suwandono and his colleague revealed that ‘Indonesian government funds, however, are not adequate to pay for all of the health services required by the Indonesian public. While public funds will be used for priority public health initiatives and to ensure that the poor have access to services, more resources must be mobilized from the community’ (Suwandono *et al.*, 2003: 20).

The response of the two health authorities differed in their handling of the limited finances available. Manado MHO was proactive in lobbying the local government in order to get support for health programmes and services to the IDPs, whereas Sampang DHO continued to accept support from central and provincial levels at predetermined levels. Moreover, while the two field research sites had financial support from similar sources for the IDPs' health, the amount allocated was different. In Manado, the local budget was greater than the central budget support, because the local government had the capacity to support finances for developing health programmes and providing health services. In Sampang, half of the total health budget depended on support for health development given by central level. This was due to the poor economic situation in Sampang District and for this reason central level gave support/allocation for the health budget.

The current health decentralisation policy automatically influenced the financial mechanism in the M/DHO. Three years after the start of implementation of health decentralisation in the municipality/district the budget flow mechanism still had a mixture of central and provincial level sources. There was still limited funding support, particularly in Sampang District, from local resources. In addition, there was little transparency pertaining to how much money the MHO and DHO allocated to the *puskesmas* for the IDPs' health programmes and services; neither did the *puskesmas* have a strong influence on the MHO and DHO.

7.4.2 Integration of Health Programmes and Services for the IDPs.

In 2004, after the IDPs had been four years in Manado and three years in Sampang, there were no longer any specific health programmes for IDPs centrally directed and locally implemented because the local health authorities had integrated these programmes with those provided for the local community. This meant there was no longer planning to handle specific IDP health needs, for example those caused by trauma.

The decision taken to integrate health programmes and services was two-fold: first, the central government decision to declare that IDPs could return home, thus ending central

support for IDPs, meant local health authorities had to take full responsibility for the health issues of IDPs. Secondly, the health needs of IDPs and the host community were considered to be similar by the local health authority and so seemed to simplify the integration of health programmes and services. It was felt this would provide a more effective delivery because resources would not have to be over stretched.

According to McLennan and colleagues “there are multiple attempts to integrate existing services. Services should be provided with guidance from the "integration-to-outcomes" model. The model identifies three ways to improve clinical and functional outcomes: 1) increase the extent to which services are effective; 2) increase the use of services by underserved populations; and 3) improve timing in the delivery of services” (McLennan *et al.*, 2003: 1).

The MHO and DHO, however, were not sure of the effectiveness and efficiency of their integration of the health programmes and services with those for the local community and it was not developed in an organized or strategic way. According to the Head of Manado MHO the practical way to handle the health issues posed by the IDPs was through integration in order to make efficient use of health resources particularly during the implementation of health decentralisation policy. This integration resulted in there being no particular care of the IDPs as a vulnerable group, nor any specific data regarding their health needs collected. For example, the IDPs regardless of their economic status had to pay indirect costs such as transportation. However this was the same for even the poorest local people.

7.4.3 Co-ordination of Health Programmes and Service to the IDPs

Ideally inter-sectoral coordination between the MHO, DHO and other sectors related to health should allow integration of programmes and extend the health services to IDPs. However, in reality the health sector and other local departments tended to work independently and this research found that there was a failure to coordinate implementation in the field. The consequences of this were overlapping, inefficient and ineffective programmes and services. For example, in Manado related sectors did not always share their programme details. Each sector was working to its own agenda.

Three key sets of relationships between the M/DHO and local government and other sectors; central and provincial level; and NGOs were considered.

i. Coordination between M/DHO and Local Government and Other sectors

The relationship of the M/DHO with local governments and other sectors was a key factor in terms of developing health programmes and provision of health services to IDPs. This was because local government, following the 1999 decentralisation policy, was responsible for deciding on the level of local health resources that would be submitted to and approved by the local parliament. Responsibility of local government for handling the complex issues of IDPs was increased. In addition, local government was a key point in coordinating the health programmes and services with the other sectors related to health.

In the past, coordination of the health programmes and services was strong under the leadership of *Satkorlak PBP* (Coordination of Implementation Unit) in Province and *Satlak* in Municipality and District, the function of which was to cope with emergency and post emergency in the location or in the recipient IDP areas, particularly during the period when the IDPs first arrived. However, during the period of research, the first emergency was over and the functions of the *Satkorlak PBP* and *Satlak* were reduced in providing support for health services to IDPs.

The complexity of organising health programmes in the two research areas was compounded by a poor understanding of the cross-sectoral health-related programmes by the programme holders and each sub-division and section at the DHO and MHO. Lack of coordination with other sectors related to health contributed to an ineffective and inefficient service at both locations. There was a lack of clear understanding on the part of the M/DHO on how other sectors could help to contribute towards the effectiveness and efficiency of health services. Programme priorities of the various sector programmes did not match and every sector focused on its own programmes.

Because every sector was working to its own agenda, it was therefore difficult for the various sectors to integrate their programmes, since the time allocated to implement them and the budgets allocated for their support were different. In that situation the overlapping of services to IDPs by different sectors could not be avoided

ii. Coordination between M/DHO and Central and Provincial levels

The role of the provincial level in health decentralisation was unclear according to the Heads of M/DHO. However, the role of PHO was crucially important in order to support both the national policies and the provincial agenda. The PHO also supplied financial support to the M/DHO.

The unclear relationship with the PHO was because M/DHO uses and applies health policies and guidance created by central level and uses the local resources as a part of the national health system. When the IDPs first arrived in these two field areas, health planning and management at the M/DHO level was still directed by central level and local health authorities were limited to a technical role in implementating of policy from central level. In addition, the central level was more focused in setting up essential health programmes and services in the initial IDP crisis in the areas where the complex emergencies arose.

Coordination of health programmes between M/DHO and central and provincial level was still complicated at the time of this research, particularly in developing health programmes based on the available resources and epidemiological trends. The dependency of the local level on central level continued to be high. Even after the integration of health programmes and services and decentralisation health policy, the M/DHO relied heavily on the centre for guidance.

The health services provided by the *puskesmas* might not have been working well because the MSS did not make allowance for local situations; that is, the target population, the local environment and the topography. Thus it would appear that the standards required in the MSS set up by central level were difficult to fulfil for the IDPs because of the varied background characteristics of demography, health determinant

factors and characteristics of the areas in every sub-district. Also, they were delivered in parallel with the health priorities designated by the local sub-district government, leading to staff overload and unclear directives.

iii. Coordination between M/DHO and NGOs

In some countries, non-governmental organizations (NGOs) (as well as other parts of the private sector, although these were not examined in this study) are major contributors to health development processes. The relationship of M/DHO with the NGOs in this case was important, considering their significant contribution to the health of IDPs.

The presence of international and local NGOs in the areas affected by conflict and recipient IDP areas were of great benefit to the public health sectors and particularly to the IDPs who needed health services in the initial stages. Unfortunately, some overlapping of health services often occurred because every organisation had its own programme. Throughout the period of their involvement in the IDP crisis, the NGOs working in Manado and Sampang made only limited approaches to the public sector when delivering a comprehensive health programmes and services to IDPs. In addition, there was no planned agenda which defined the health programmes with clear pathways and agreed guidelines. There were no competent and routine outcome measures, including lines of communication and responsibility, in order to ensure appropriate health programmes and services to the IDPs.

During the period the survey was conducted, there were no longer any NGOs working in these two areas, but some items of equipment had been donated to the *puskesmas*. For example in *Puskesmas* Ketapang Sampang, there were several pieces of medical equipment as well as a new donation of an ambulance from an NGO. These donations could create problems with the local government, where NGOs who are phasing out and donating their belongings often do not realize the limited capacity at municipal and district level to use, store or dispose of these ‘donations’ or pay for their maintenance. Such a situation may create new unnecessary problems at both M/DHO and *puskesmas* level.

In sum, all the above aspects of coordination influenced the health of the IDPs but did not necessarily respond to their health needs, particularly for those who were desperate for health services. Lack of service delivery capacity, especially of human resources, was responsible for the limited coverage of health services, particularly in Sampang. Besides, the health authorities in the district had concentrated almost exclusively on provision of health services, with limited recognition of the capacity of the other sectors for service delivery. As a result, every health programme worked according to its own agenda and the organisation of health services in the field areas was highly concentrated on health strategies and interventions that were developed independently by either the health sector or the sectors related to health.

Co-ordination of health programmes and service to the IDPs is important in health systems because of the alteration due to integration of the programmes and services to the IDPs. Hall and colleagues mention that integrating health programmes with related sectors can lead to greater efficiency and improved access to services or more equitable treatment. This can help to build stronger community support and accountability for services (Hall *et al.*, 2005). Multiple parties providing healthcare were often inadequately coordinated, integration and coordination of health services in the two research areas remained poor, as the public sectors relevant to health were working to their own programmes and the NGOs providing health services overlapped with the public sector services.

7.5 Challenges to and Limitations of the Research

Several limitations in the research process can be identified. Firstly, in the planning period with the Indonesian Health Authority there was a conscious decision taken to strive for breadth versus depth. This meant that a large number of variables were covered by the questionnaire. However, many variables limit the depth of information.

Secondly, the sample size in the survey is too small, which makes it difficult to detect differences among groups (for example age, gender, household status) when they may actually exist. Research experience by WFP revealed that "small sample sizes can lead to inconclusive or misinterpreted results since inferences are drawn on a small percentage of the population, those sampled may not be highly representative of the overall population" (WFP, 2002c: 4). However, the procedure for sample design incorporated direct observation, focus group discussion, secondary data sources and input from M/DHO in both field areas to maintain a balance of data collected across methods. There have therefore been opportunities for corroboration. One potentially distorted source has had a limited effect on overall conclusions

Thirdly, due to time and resource constraints, the study was limited to one sub-district in Manado and 3 sub-districts in Sampang. Since the selection of sub-districts affected the findings, the findings cannot be considered applicable to other areas within the region or the country. The research revealed how the impact of the conflict from other parts of the country affected the health system in the recipient areas and contributed to the challenges of the health decentralisation policy process.

Given these constraints, it was not possible to draw a causal linkage in either direction between the large number of IDPs, their health conditions and the ongoing process of health decentralisation. Therefore, the focus of the research was not on making judgments about impact in either direction, but rather on identifying existing conditions in order to provide recommendations for the recipient areas' health authorities.

Fourthly, language and cultural barriers meant that interviews with the Madurese speaking IDP respondents in Sampang had to be conducted through an interpreter. Therefore, the compiled responses, particularly in focus group discussion, may be biased by use of the interpreter.

A further limitation was encountered in conducting some of the focus groups, particularly in Sampang District. During the focus discussion process, sometimes the informal leaders were dominated the issues that brought up into the discussion. In addition, some (mainly young female) respondents did not participate much and tended to be quiet, making only a slight response to the issues brought to the discussion. The results may inadequately reflect the views of that group.

The next chapter contains the conclusions and recommendations of this research.

Chapter Eight

Conclusions and Recommendations

8.1 Conclusions

Development of essential health programmes, providing essential health services and fitting them into the local health systems of the recipient areas could minimise the impact of the complex emergencies on the long term health of IDPs.

Several conclusions emerged from this research. Firstly, the respondents stated that their distressing experiences from their flight to their extended stay in recipient areas affected their health status, which in turn, increased their health needs in the recipient areas.

Secondly, the health needs of the IDPs were influenced by many other factors. From the qualitative data collected, particularly through direct observation, this included the condition of the temporary accommodation and living conditions, particularly in Sampang; inadequate clean water particularly for those IDPs who lived in the woods surrounding Robatal Sub-district in Sampang; and lack of sanitation awareness of some IDPs. The survey included household allocation in the temporary accommodation, the characteristics of household respondents, length of stay, access to and utilisation of health services.

Thirdly, the influx of IDPs into the safe areas had an impact on the health systems in these recipient areas. The presence of IDPs created new health requirements. As a consequence, the local health authorities had to expand their health programmes and services to cover the health issues of the IDPs.

Planning health programmes and services requires accurate information regarding local health issues to be collected and utilised. The newly devolved responsibilities of local health authorities presented an opportunity for this to be written into their plans, but due to their limited capability they had not taken advantage of this.

Fourthly, health decentralisation policy affected local health systems particularly in relation to their organisational structure, health resources and the development of health programmes and provision of services by the MHO, DHO and *puskesmas*. The two recipient areas were struggling to adjust their health systems to deal with the local community's as well as the IDPs' health issues in order to accommodate the health decentralisation policy. Dependency on the guidelines from central level was high. As a result the local health authorities had limited ability to explore potential health threats and create suitable health programmes and services based on specific local circumstances.

Fifthly, when IDPs had lived in an area for a number of years, there were no health programmes and services tailored to their continuing particular health needs. Disharmony and lack of coordination among local government sectors related to health on the one hand, and national and international NGOs on the other, had caused opportunities to give health support to the IDPs to be lost. The vulnerability of the IDPs in recipient areas was overlooked when the essential health programmes from central level were ended. Extending the local community's health programmes and services to cover the IDPs did not entirely address their health needs.

Sixthly, the availability of health resources varied according to local conditions and health resources. This situation had an impact on the development of relevant health programmes and service provision to the IDPs to fulfil their health needs.

Health system issues, particularly in some municipalities and districts in Indonesia, are complex. In those that received IDPs, there were different responses in terms of developing health programmes and providing health services to address the health needs brought by the IDPs. Since the decentralisation health policy, the health needs of IDPs

have become the responsibility of the recipient area's local health authority. The findings of this research underscores the need to augment local public health authority resources in the recipient IDP areas in order to address the ongoing health needs of the IDPs, whether or not they decide to return to their homelands, and in particular those who decide to settle in the recipient areas.

This study found that, in declaring an end to the IDP crisis in all the provinces that had received the IDPs, the government left the M/DHO with a confused situation i.e. they still had IDPs, although the government stated that there was no longer any need for extra programmes. The removal of central level's responsibility left local recipient areas with limited planning ability and resources for dealing with the health issues and needs of their IDPs.

8.2 Recommendations

This research investigated the health needs of the IDPs who lived in exile in a municipality and district in two provinces in Indonesia. It presents an analysis of the elements of health systems in recipient IDP areas, and also highlights the ways in which the IDPs received essential health programmes and services provided by the local health authorities. It covers health decentralisation policy in IDP recipient areas.

The motivation for this study was two fold: firstly, very few studies had dealt with the impact of complex emergencies on recipient areas from a health system perspective, and secondly the availability of effective interventions to improve the health of IDPs in recipient areas that are in the process of carrying out the health decentralisation policy is limited.

Based on the findings from this research and the conclusions presented above, the following recommendations are made, from the perspective of health systems, for effective interventions towards the health needs of IDPs:

1. Redefinition of functions at M/DHO levels. Since the organisational structure of M/DHO was restructured due to the decentralisation policy, a need has arisen to redefine the functions of the health system at central, provincial and municipal/district levels and to determine how health institutions should develop in order to ensure increased effectiveness and local support. There is a need for central level to be willing to empower the local level, in particular with financial and human resources support.

On the other hand, it is believed that the decentralisation policy promotes efficiency and effectiveness in the health services because of its improved organisation and decision making process. Clear distinctions are needed to organise the programmes and resources between the central, provincial and local levels.

2. Adjusting the new roles of every level of health sector. All institutions will need to adjust to their new roles and build and strengthen networks at every level. In other words, up to the present time the roles and responsibilities shared by central and local government have not been clearly defined and understood. There is a need to increase cooperation between the sub-divisions within M/DHO, also between the upper level and M/DHO, through setting up a clear direction for every programme designed by them to be linked with all health programmes in the priority health services to the IDPs. This could be achieved by linking some closely related operational tasks of sub-divisions in organisational structure, for example, MCH, immunisation, and family health programmes.

3. Policy development. There is a need for development of proper policies to cope with the issues arising from both the IDPs and the public health sector, particularly by the local health authorities in the recipient areas. The Ministry of Health of the Republic of Indonesia could promote initiatives to assist the local level to develop policies in order to improve the health of the IDPs.

4. Involving the IDPs in the health development. It is important that displaced persons have access to involvement in the policy-making process in order to open up channels of dialogue with health decision planners, to clarify misunderstandings and build a relationship between health providers and IDPs. There is a need to involve the IDPs in developing health planning programmes based on their own perception of their health needs and to involve them in the implementation of health programmes e.g. healthy environment, water and sanitation. Any particular group of IDPs will have their own ideas and habits, for example regarding methods of sanitation and other issues, which have to be understood by those who are trying to help them.

5. Commitment and coordination of parties involved in the health of IDPs. There needs to be a high commitment between the health provider, the related sectors within local government, and the representative of the legislature to coordinate programmes. In addition, there has to be improved coordination between M/DHO and NGOs (international and local) and other private providers interested in health. The role of *Satkorlak PBP* and *Satlak* in leading coordination at the local level for providing health and other services has to be maintained through regular coordination with other sectors. This is to ensure the most productive use of health services and that resources are being adequately applied to the health needs of the IDPs.

6. Exploring the local resources by M/DHO to support the health programmes and services. As the purpose of health decentralisation is to empower local authorities, there is a need for local health organisations in the recipient areas to explore their potential ability to support the health programmes for IDPs. The local government could be approached to support the health programmes and priorities with available resources as suggested by the Manado MHO. The Head of Manado had taken the initiative to lobby the local government to increase the budget for the local health sector through active presentation of the municipal health profile.

In a situation where local resources were inadequate, the central level could be called upon for assistance. For example, Sampang District is the poorest in East Java province.

Given its demographic, economic and geographic constraints and with regard to the needs of the district and the available health resources for providing health services to the IDPs, the M/DHO could approach the central level to increase the DAK budget and attract health workers to districts like Sampang through increasing incentives or offering opportunities to develop their careers.

7. Transparency in bidding and procurement of drugs and medical supplies. Bidding and procurement of drugs and medical supplies needs to conform to the guidelines for a bidding process. Reform in the bidding process is crucial. The participation of the private companies involved in the bidding process has to be carried out in a clear and transparent manner.

8. Updating the disease epidemiology in the recipient areas. There is a need for epidemiological surveillance of the IDPs' diseases to inform the health decision makers and health programmers. Sources of information should include morbidity, disability and mortality information, case and epidemic investigation, laboratory isolation and identification (particularly the endemic diseases such as diarrhoea, malaria, dengue haemorrhagic fever) and other relevant epidemiological data. It is also important to provide socio-economic and cultural data that influences health status. This information should be updated and stored to act as a resource for the local health authorities.

9. Provide adequate health information. Provision of accurate health information is essential for the health of IDPs, so that necessary health programmes and facilities in their recipient areas are recognized by them. Information about procedures and the availability of health services are important so the IDPs have access to the existing health services. Greater information awareness of the social dimensions of health leads to better understanding and cooperation between the health providers and the recipients. Health information should be a two way system, the providers need information from the recipients as to their perception of service provision and delivery and so a system for such appraisal is required. This would clarify the reasons why people choose to use/avoid public services and lead to increased efficiency and effectiveness in health provision.

10. Improving the out-reach health programmes and services. In addition to the existing health services, there should be an out-reach programme for those in temporary accommodation. The IDPs in this accommodation are the poorest and most deprived and the cost of transport to a health facility can be beyond their means, thus preventing them from receiving health care. There is a need to set up regular schedules for out-reach programmes, particularly for those who lived in remote places.

11. Create a health service package for the IDPs. There is a need to create a health service package for IDPs. This package should be free of charge for those IDPs who have been officially identified as eventually returning to their homeland. Those who wish to settle in the recipient areas could be treated in the same way as the rest of the population. Not all IDPs are poor; however all poor and vulnerable IDPs should be exempt from health service fees at all times. Local communities already have a mechanism for identifying such people; this would be extended to cover those IDPs who have chosen to be part of the local communities by settling in the area.

12. Ensuring a better quality of health service delivery and strengthening the referral health systems. In a health service setting, particularly in the *puskesmas*, ensuring a better quality of health service delivery has to be effective and efficient, particularly in basic medical treatment. Diagnosis and treatment of the IDPs' diseases should be evidence based, using clinical guidelines. Moreover, it is essential to provide quality drugs for accurate diagnosis and a regular mental health service with visiting expertise. Both the providers and the recipients may have differing perceptions of what constitutes quality health provision, so there must be a simple means of communication between these two groups.

There is a need to strengthen the referral system and rationalise the distribution of facilities and services. Providing a standard management protocol for the referral system that involves other sectors, the local community and IDPs, is important. The expense of referrals from puskesmas that are a distance from a hospital requires special consideration in budgetary planning.

13. Support for local health workforces. Opportunities for and encouragement to take advantage of training in the new skills required as a result of decentralisation and increased responsibilities should continue to be provided by central level – because only they have the necessary experience and expertise. It should be designed to gradually decrease dependency on central level.

14. Financial support. It would be reasonable to expect municipalities to be able eventually to support their own health programmes and services by drawing on local resources, but poor and rural areas have little prospect of this and will require central level support for the foreseeable future. Therefore, central and provincial levels will have to continue to allocate budget support through health care finance.

15. Improving and maintaining the temporary accommodation. Temporary accommodation falls into two categories: that built on government land and that on land owned by local people. The accommodation on government land should be improved and maintained for those who prolong their stay in the recipient areas.

8.3 The Need for Further Research

The process and results of this research indicate the need for further research on the health system, the effects of the health decentralisation policy, and specifically on the IDPs' health needs in recipient areas. In particular, there is very little documentation and research into the health needs of IDPs and the health systems in IDP recipient areas which takes account of the particular characteristics of both the areas and the conflicts which caused the people to become displaced. This research provides insights into two populations and contexts.

There is also no literature on the subject of IDPs' health in conjunction with health decentralisation policy, particularly in the process of health decentralisation policy in urban and rural areas.

Very little literature exists on the subject of health policy and health programmes and services for vulnerable IDPs, including the disabled. More research in this particular area is required to produce recommendations to minimise or dismiss risks for this group.

There is little literature on the interaction between the IDPs and host communities in terms of integration of health programmes and services. This is important because the burdens on the local health authorities in order to extend the health programmes and providing health services are increasing.

The relationship between decentralisation policy and the impact of ethno-religious conflict, particularly in the recipient IDP areas could be explored through comparative studies, either using an inductive design or with the help of theoretical models.

Owing to internal tensions, the situation in Indonesia remains restive with continuing instability in politics and society as a whole. The causes of the complex emergencies need to be tackled. While complex emergencies resulting from conflict or natural disaster continue, a commitment is required by the national government to create secure environments and that adequate co-ordination is followed through by those responsible in harmonising multi-sectoral efforts particularly in the affected areas. The impact of complex emergencies on the health of IDPs and the gap between IDPs and health providers could be minimized and closed through early cooperation by all stakeholders. Health authorities empowered by the continuing process of the health decentralisation policy will be better able to bridge the gap.

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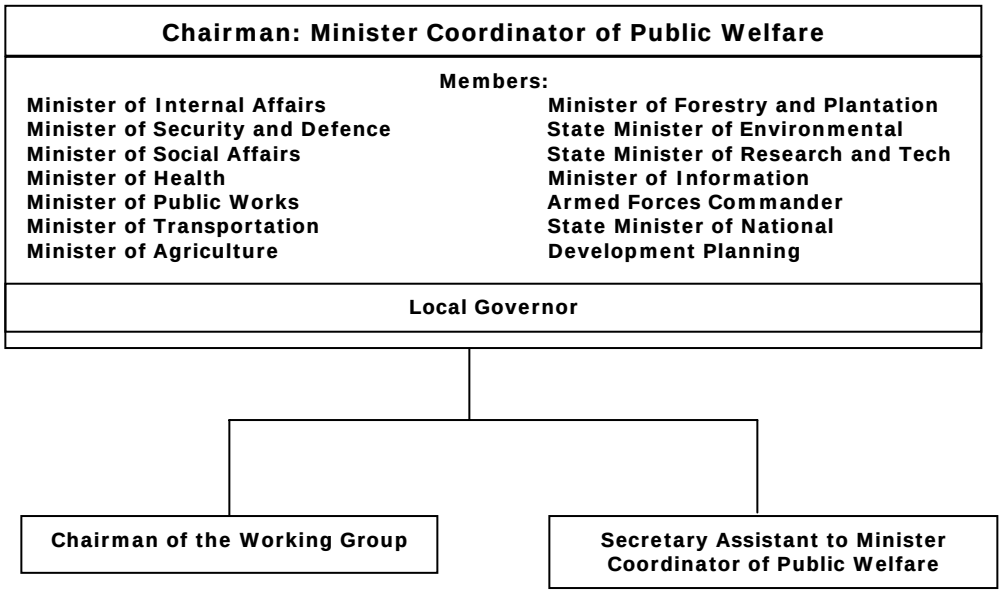
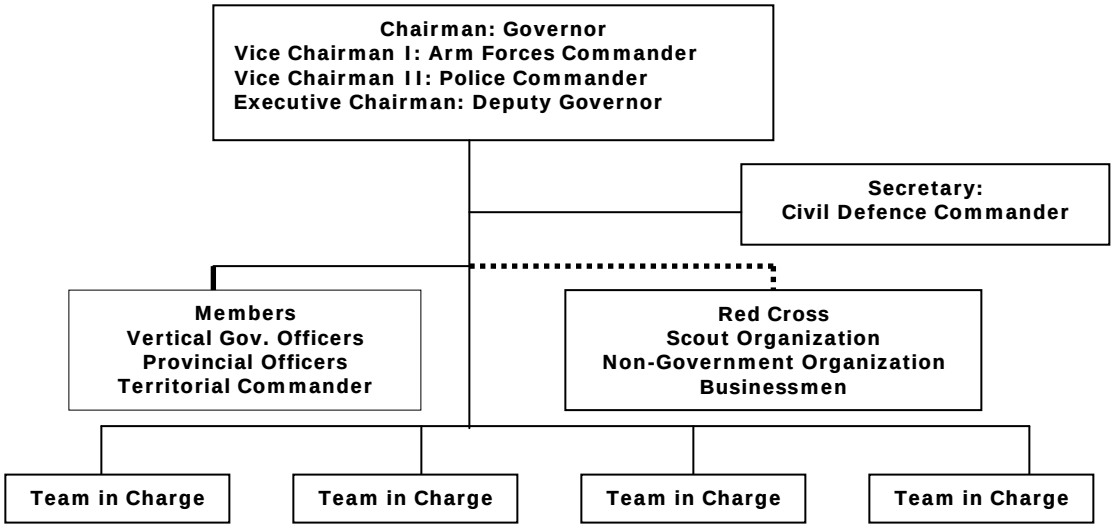
Appendices

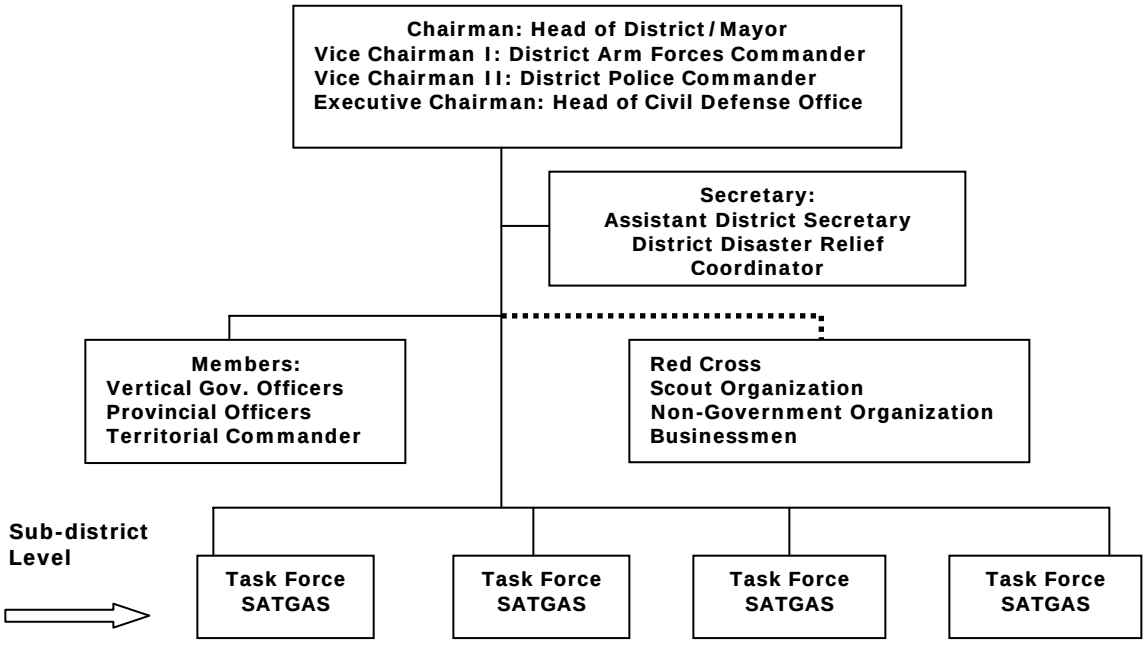
Appendix A: National Disaster Management Coordinating Board (*Bakornas PBP*)



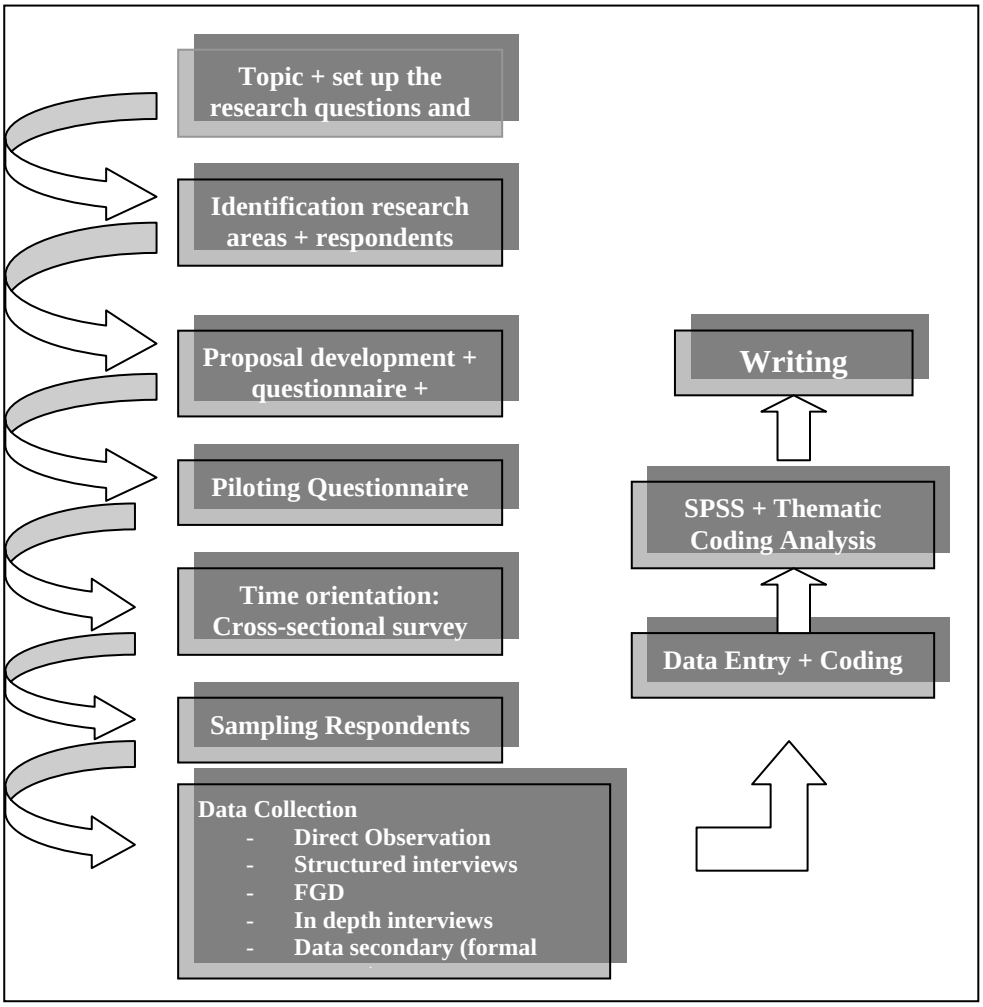
Appendix B: Provincial Disaster Coordinator Implementing Unit *(Satkorlak PBP)*



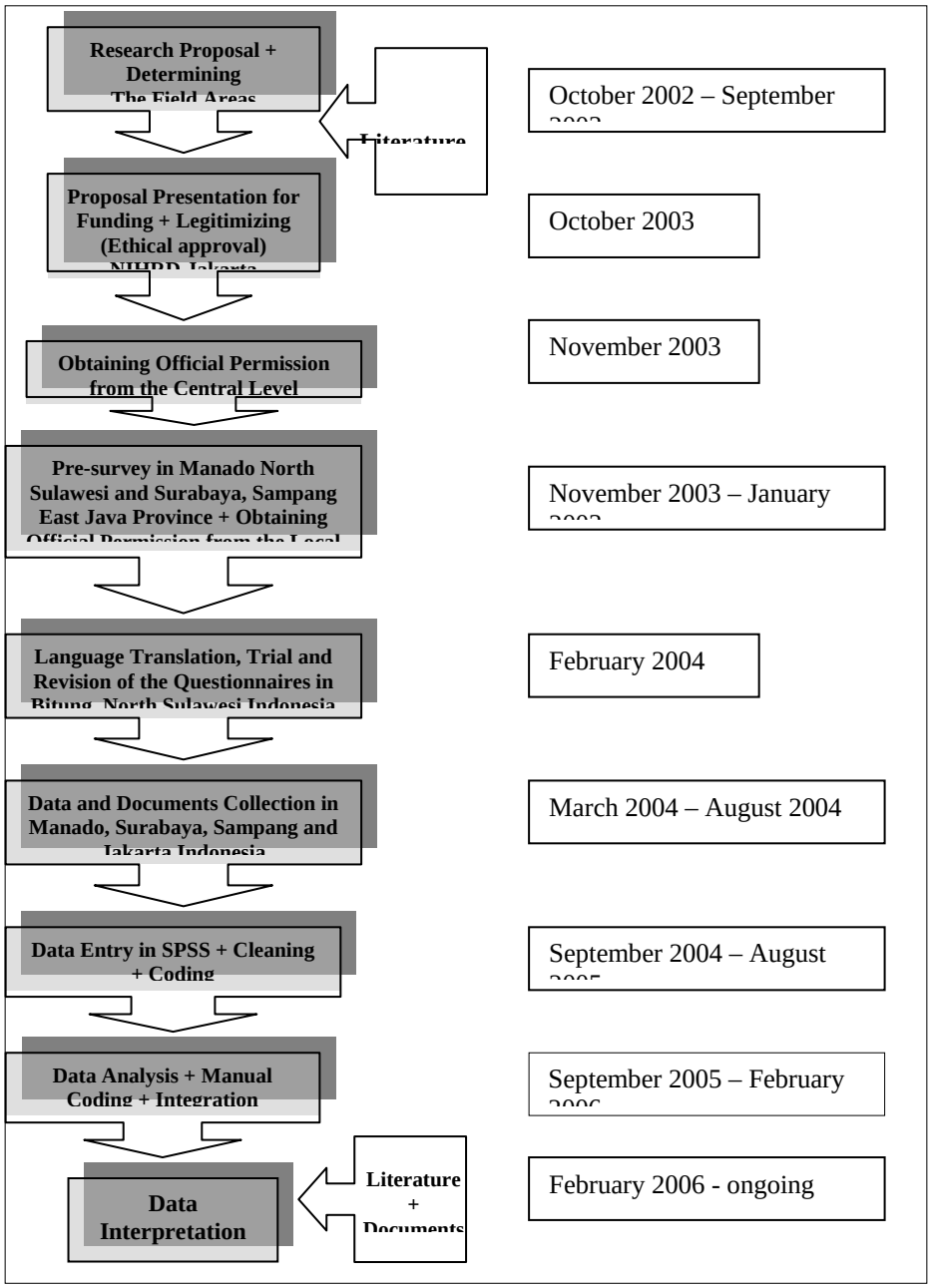
Appendix C: District Disaster Management Implementing Unit (*Satlak*)



Appendix D: Research Design



Appendix E: The Research Process



Appendix F: The Questionnaire Survey for IDPs

ENABLING THE INDONESIAN HEALTH SYSTEM TO BETTER MEET THE NEEDS OF DISPLACED POPULATION: AN ANALYSIS OF POTENTIAL RESPONSES

CONFIDENTIAL

I. PLACE ORIENTATION			**CODE**
1.	Province		
2.	District/municipality		
3.	Sub-district		
4.	Village		
5.	Area	*Urban -1* *Rural -2*	
6.	Type of Accommodation	1. Barrack 2. Family house 3. Rent 4. Own house 5. Very Simple house	
II. HOUSEHOLD			
1.	Name of household Head		
2.	Name of respondent		
3.	Number of household		

III. RESEARCHER VISITING

1. Finished 3. Postponed
2. Partially completed 4. Refused 5.Other:_____

	INTERVIEWER	
Name		
Date		

TIME Start …..... Finish...…… Total …..hour ……minutes

PART 2. HEALTH STATUS AND USING CURATIVE CARE			
12.	In the last month, since you have been staying here, have any members of your household suffered from diseases? 1. Yes 2. No to Q. 19		
13.	If yes, who was ill?…… What kind the symptoms did they have? (Please explain) ……		
14.	During the time he/she was ill, where did he/she go for the first treatment? (Please put in order your first, second, third choice etc).		
	a. Hospital		
	b. Community Health Centre		
	c. Health Post		
	d. Doctor or Nurse in private practice		
	e. Private Clinic		
	f. Self treatment		
	g. Traditional healer		
	h. No treatment		
	i. Referral 1. Yes 2. No		
15.	Is he/she still ill now? 1. Yes 2. No		
16.	a. If yes, do you know what the disease is? …… b. What kind of drugs was he/she prescribed? ……..		
17.	Is there any support funding or other support to cover the cost of treatment or admission to the hospital or community health centre? 1. Yes 2. No		
18.	If yes, from which sources? 1. Government 2. Private/NGOs 3. Self 4. Others (please explain)		
19.	Have any of your household members become disabled during your stay here? 1. Yes Who was that ? …… 2. No		
20.	Have any of your household members died during your stay here? 1. Yes 2. No skip to Q. 24		
21.	Which of your household members died during your stay here? 1. Son/daughter 2. Wife 3. Husband 4. Others		
22.	When was his/her death? ……..		
23.	Do you know what the cause of death? ……..		

PART 3. ESSENTIAL HEALTH PROGRAMMES – MCH, INFANT/CHILD IMMUNISATION		
24.	During your stay here, have any women in your household become pregnant? 1. Yes 2. No skip to Q. 32	
25.	Where did she go for ante natal care? And how many times? 1. Community Health Centre 2. Hospital 3. Health Post 4. Others (please explain) 5. No at all	
26.	Has any baby been born during your stay here? 1. Yes 2. No skip to Q.32	
27.	Where was the baby born? 1. Home 2. Community Health Centre 3. Hospital 4. Other (please explain)	
28.	When was it born?	
29.	Who was the assistant during the delivery? 1. Doctor 2. Midwife 3. Nurse 4. TBA 5. Others (Please explain)	
30.	Who paid for the delivery? 1. Government 2. Private/NGOs 3. Family 4. Others (please explain)	
31.	Where did she go for post natal care? 1. Community Health Centre 2. Hospital 3. Health Post 4. Others (please explain) 5. Nowhere	
32.	For women only; are you using contraception for birth control? 1. Yes 2. No	
33.	Does your child have a health card (KMS = *Kartu Menuju Sehat*)? 1. Yes 2. No.	
34.	Where did you go for your child's immunisation and weight check? 1. Health Post 2. Community Health Centre 3. Hospital 4. Others	

PART 4. FOOD/MEALS		
35.	How many times do you eat food/meals? 1. Once a day 2. Two times a day 3. Three times a day 4. more than 3 times a day	
36.	What kind of food/meals and additional food are you eating each day? 1. Rice 2. Corn 3. Sweet Potato 4. Sago Additional food (please explain)	

37.	In your opinion, do you think the food/meals are enough for each day? 1. Yes 2. No	
38.	Where did you get your food/meals from each day? 1. Government 2. Private/NGOs 3. Both 4. Self supported 5. Others (please explain)	

PART 5. HEALTH ENVIRONMENT AND SANITATION		
39.	Do you have a bathroom and a place for washing your clothes etc? 1. Yes 2. No	
40.	If No, where do you usually go for bathroom and washing your clothes etc? ……	
41.	Do you have clean and drinking water? 1. Yes 2. No	
42.	If yes, where do you usually you get the clean and drinking water? ……	
43.	Who provides clean and drinking water? 1. Government 2. Private/NGOs 3. Self supported 4. Others (Please explain)	
44.	Where is your place for defecating? 1. Toilet 2. Others (Please explain)	

PART 6. PUBLIC HEALTH SERVICES		
45.	Have you heard about health promotion? 1. Yes 2. No	
46.	If yes, where did you hear it? 1. Government 2. Private/NGOs 3. Others (Please explain)	
47.	What kind of health promotion issues did they promote? (Please explain) ……..…… ……	
48.	To your knowledge, has there been any government programmes to empower IDPs' health in the last 3 months in this district? 1. None 2. Few 3. Quite numerous 4. Abundant	
49.	Imagine, this district/municipality has a large amount of funds, in your opinion for which purpose would it be best used? 1. Improving the camps/resettlement environment 2. Poverty Alleviation 3. Improving health services 4. Improving the quality of other public services 5. Other……	

50.	Does your household have a health card for health services? 1. Yes 2. No	

PART 7. HEALTH DECENTRALISATION POLICY		
51.	Have you heard about the local autonomy issue? 1. Yes 2. No skip to Q. 53	
52.	If yes, what do you know about local autonomy?	
53.	This province and district/municipality has been undergoing local autonomy since 1999 and health decentralisation in 2001. In your opinion, what is the quality of the service in the community health centre and hospital in the district/municipality? 1. Excellent 2. Good 3. Fair 4. Bad	
54.	Would you please rate the health service where 1 is the worst level of service and 5 is the best? a. Community Health Centre 1 2 3 4 5 b. Doctor of Community Health Centre 1 2 3 4 5 c. Nurse and Village Midwife 1 2 3 4 5 d. Posyandu (health post) 1 2 3 4 5 e. Others 1 2 3 4 5	

PART 8. SECURITY & LOCAL GOVERNMENT		
55.	During your stay here, do you feel secure? 1. Yes 2. No	
56.	If not, why? (Please explain)	
57.	During your stay here, have you wanted to go back to your original place? 1. Yes 2. No skip to Q.59	
58.	If yes, what is your reason?	
59.	If No, what is your reason?	
60.	How good is your social relationship with the local/host community? 1. Excellent 2. Good 3. Fair 4. Not good	
61.	In general how well does the local government care for your situation? 1. Very care 2. Good 3. Fair 4. Careless	
62.	What are your suggestions for the future in terms of health development from the government to improve the IDPs' health status?	

PART 9. PRIVATE AND NGOs INVOLVED IN HEALTH SERVICES		
63.	Is there any health services support from other institutions? 1. Yes 2. No	
64.	If yes, where did the support came from?	
65.	What kind of health support do they offer? a)…… b)…… c)……	
66.	Have they provided any other support to you in addition to health? 1. Yes (Please explain) 2. No	

Thank you very much for your participation.

Appendix G: Protocol for Focus Group Discussion

Good afternoon, I would to say thank you for being a participant in this focus group discussion and I would like to explain what particular issues we will discuss; they concern the living conditions, personal health problems; health environment and sanitation; water supplies; access to health services; the health services offered by local health authorities; and security including social interaction within the host community.

1. Describe how you and your family arrived in this camp?

2. Tell me about the conditions of the accommodation in which you are now living.

3. How do these conditions affect your health?

4. How do you cope if you have an illness?

5. What are the health services available in this area?

6. What are your experiences in obtaining health services in this area?

7. How satisfactory are the health services offered by the public health sector in this area?

8. How do you access the health services provided by the public health sector?

9. Is there any health project you know of for this temporary accommodation?

10. What are your suggestions particularly for health services in this area?

11. What kind of relationship is there with the local community and what do you feel about security in the temporary accommodation?

Appendix H: The Letter of Ethical Approval

Appendix I: Statement of Agreement

Statement of Agreement

Good Morning/afternoon, my name is…….
I am a health student and health researcher from The National Institute of Health Research and Development, MoH RI. I would like to do a survey about health status and needs of the displaced population for the health public service. We would really appreciate it if you could allow us to interview you and your family for this purpose. Your answers will help the government especially the local health authority to improve the health services for displaced persons, in terms of planning and establishing the health programmes and services. This interview will take around 30-40 minutes. Whatever answers you give us will be considered as a highly confidential and we will not share these with other people or institution.

Your participation in this survey is voluntary and you may choose not to be involved in this survey, but I would really be appreciated if you could give me your answer to the following questions.

We would also be very happy to answer any question you have or anything you want to know about this survey. We will explain in as much detail as we can.

Could I start the interview? and if you agree could you please sign in on this paper.

Respondent's signature :_____
Date:_____

Interviewer's
signature:_____Date:_____

Appendix J: Transcripts of Focus Group Discussions

1. Focus Group Discussion in Mapanget Sub-district

Q. Tell me how you and your family arrived in this temporary accommodation.
- After the riots we came directly from North Maluku province to Manado City, where we lived in several places before we came to the temporary accommodation here in Mapanget Sub-district (man).
- I came here with my family after I stayed in my family's house in the other island, but still in this province (man)
- My family and I came here after we stayed in the government building in the city for about 1 year (woman).
- My experience was also similar to that of this woman… my family and I lived in the government building in the city (man).
-Two and half years ago…. we decided to move from our previous temporary accommodation to this area….because the previous temporary accommodation was the community centre owned by the Local Government. There was lack of space for our beds, for cooking our food and washing our clothes. The toilets were also minimal in terms of numbers and the piped water supply was intermittent. The situation in the previous temporary accommodation was not good for our health (man).

- When we first arrived here several NGOs were providing not only health care but also the infrastructure and other programmes for us. In my experience some health programmes and services provided by the NGOs or private organisations were similar to those of the public sector (woman)

Q. Tell me how about the conditions of the accommodation in what you are now living
-We believe that living in the brick house is better for us compared to the place where we stayed before. However, some of the brick houses are in poor condition because we don't have money to maintain them (man).
- Yes it is true! Also the roads connecting to other brick houses are damaged and muddy. Moreover, many of us who live in these brick houses become ill, particularly in the rainy season (woman).
- We need support from the government to renovate the brick houses because some of them are damaged and their condition is not good for our health. Our health is also affected by the rainy season and some of our house roofs leak. Access to some of our houses is difficult because of the location of the house on the hills and in the valleys and during the rainy season it is slippery because of the mud (elderly man,).
- Yes I agree with this man, because we don't have any support to maintain the houses that we live in (woman).
- We need building material to renovate the houses so we can stay properly for a while and protect us from the bad weather because often with strong winds affect this compound area (young man).
- The water supply in this temporary accommodation area is easy to access. We can take clean water from the well and also piped water. To wash our clothes we use water from the river (woman). Yes we use the river for our source of water to wash our clothes and utensils (woman).
Q. How these conditions affect your health?

- Living in this area, we also suffer from diseases. Certain types of disease symptoms such as the common cold and coughs are frequent particularly in the wet seasons in this area (man).
- Not only, the diseases we have here but also we also suffer from stress. Our experiences in the conflict are very difficult to wipe out from our minds (woman).
- Yes! It's bothered us so much in our daily life…we had difficulty in handling that stress (woman).

Q. How do you cope if you have an illness?
- If we have an illness we buy a drug in the small store in this area, especially if the disease is fever, cough or flu…that kind of illness we feel is not too serious, but if the illness were serious we would go to the *puskesmas*, although we need more money to cover the cost of going to the *puskesmas* or hospital to get treatment (woman).
- Yes, but sometimes we just ignore the diseases because we don't have enough money to buy the drugs (man).
- We are most concerned about mother and child health and also diseases such as communicable diseases, fever and cough symptoms, skin diseases, stress and trauma (man).

Q. What are the health services available in this area?
- The health programmes and services that available in this area as I remember is MCH, immunisation (man).
- Health environment programmes are also provided by the *puskesmas*, such as controlling the mosquitoes though spraying the lagoon near the river…. because that place is the breeding places for mosquitoes (young man).
- Family health programmes are also offered by the *puskesmas* (man).
Contraception methods are very easy to find in this area, but in order get the family planning service offered by the health facilities I had to pay Rp. 25,000 = £2 for the contraceptive method (woman).
- Water supply programmes came from the government and non-government organisations and improved the access to water by prepared wells for water drinking and washing in the temporary housing areas (woman)
- I know that …. we can have basic medical treatment in the *posyandu* …including weighing our babies and sometimes our babies have a green bean meal provided by the *posyandu* (woman).

Q. What are your experiences to obtain health services in this area?
- My experience during my pregnancy…I felt fine during my pregnancy and it was unnecessary for me to have a check-up in the health facilities. Also this was because we didn't have enough money for transport to go back and forward to the health facilities either to the puskesmas or hospital (woman).
- We heard that the price for delivery in hospital is about Rp.50,000. This is too much for us and also we have to pay for the transport to get to the hospital. We hope that there will be a solution for these issues and we need your help to forward this message to the local health authority in the city (man)
- I preferred to deliver my baby in my house; it was more convenient because I felt comfortable compared being in the *puskesmas*. I just felt uncomfortable about delivering in the *puskesmas*. And …I delivered my baby with the TBA's help and the delivery process was safe, the baby was fine (woman).
- I felt fine after delivery and considered that post natal care was not required" (woman)
- We almost always used the health facilities and the health post (*posyandu*). We were using the health facility for pregnant woman and the immunisation program that was conducted by the

puskesmas which ran a *posyandu* regularly in the church building in this compound area (woman).
- The ANC services that I received during my antenatal care were varied depending on the type of health facility, in the *posyandu* there was regular control of my pregnancy and in the *puskesmas* blood from my finger was taken (woman).
- There is a program for immunising our kids but our culture believe that an infant under six months old should never be injected, we just believed this because our parents did the same for us, when were lived in our homeland (elderly man)
- Food in our place here was enough especially at the beginning of settlement in the relocation area. We occasionally got support from sources such as WFP and NGOs. The food consisted of rice, noodles, fish and canned meat as well as biscuits and milk (woman)
- When I visited the *puskesmas* to cure my disease, the drug that I received was similar to the drugs that my friend received, although we suffered from different disease symptoms (woman).

- When my daughter had a fever, we worried so much and we didn't want to give her just any or trifling drugs that we could buy in the shop… went to the *puskesmas* to get a physical examination, treatment from the doctor or nurse for her illness and advice on what we could do for her (man)
- The availability of medicines is enough but only the generic drugs and the drugs are the same all the time (woman).
- We use the health facilities in order to have health services particularly basic medical treatment if a member of our household is sick. We also use the health facilities to control our household members if they are pregnant (woman).

Q. How satisfied the health services offered by the public health sector?

- When I went to the *puskesmas* to get treatment, I was controlled by the nurse there who was very kind to me and skilled in terms of giving me advice and drugs, although during the interview my disease symptom only less than 5 minutes (woman).

- Yes…I also went to the *puskesmas* to control my illness and the doctor helped me to treat my disease…he was a nice doctor and he willing to listen to my complaints (woman).

- I was not satisfied with treatment in the puskesmas. Moreover, the communication between me and the health worker was too short, I needed more information about the illness from which I suffered so much (woman).
- When I visited the *puskesmas* to cure my disease, the drug that I received was similar to the drugs that my friend received, although we suffered from different disease symptoms (woman).
- The attitude of the staff is sometimes nice sometimes not, and also we have to understand the meaning of the local language…. but because we have lived in this temporary accommodation for 3 years, we understand, what the health officers are talking about. In terms of a health card for free treatment we don't have one and we don't know about that (woman).

- For health cards I know about that and we used that card to have treatment in health facilities in our homeland. I have never tried in this area (man).

Q. How do you access the health services provided by public health sector?
- Access to the *puskesmas* in terms of distance to and from our temporary place here is about 4 km and we have to use public transport, but unfortunately the public transport is not regular….the locations of health facilities are too far from our place and we need transport to go

there… we don't have enough money to pay for the transportation and to buy the drugs, particularly the drugs that we have to buy in the pharmacy (woman).
- Yes I agree, with her, if we have to go to the hospital the distance between the hospital and this place is about 20 km and again we need transportation to go there (man).
- We also have to pay a fee for health services in the *puskesmas* - Rp 2.000 = 2 pence for health services, and sometimes we have to pay Rp. 2.000 for a syringe for an injection we just think there ought to be a policy for us the IDPs to have free health services, the same as it was in the beginning when we arrived here (woman).

Q. Is there any health project you know for this temporary accommodation?
- We don't know about the health project in this temporary area, we just know that there was a new *pustu* built by the local government, but there is no health service available (man).

Q. How is the relationship and security in the temporary accommodation?
- We have a good relationship with the local people, even though sometimes we have had frictions such as the matter of distribution of water through water pipes and tanks. The water supplies provided by NGOs were supposed to go to the IDPs, but unfortunately the water system went to the local community instead (man)

- We are willing to return to our original places in Maluku Utara for many reasons such as: we are looking for a job, the properties that we left during the conflict; family and friends and the opportunities for living there (man)

Q. What are your suggestions particularly for health services in this area?

- I think we also need services such as regular health promotions so we can understand and gain knowledge about what we should do for our health during our stay in this temporary house (man).

- Yes…we also need to improve the programme for eradication of communicable diseases, especially malaria, and dengue fever and dengue hemorrhagic fever; for example regularly spraying and fogging this place to avoid malaria and dengue fever (woman).

- We also hope we don't have to pay fees for services that include drugs and injections in the *puskesmas,* because we don't have money to pay for that (woman).

2. Focus Group Discussion in Ketapang Sub-district

The focus group was conducted in the barracks and the group consisted of seven participants: one informal leader of IDPs, two heads of households, one elderly person, two housewives and one young man.

Q. Tell how you and your family arrived in this camp?

- After the riots first we came to South Kalimatan province and to here (man).
- I came here with my family after I stayed in my family's house Central Java province (man)
- We came here directly from Sampit Central Kalimantan by using the boat (woman)

Q. Tell me how about the conditions of the accommodation in what you are now living?

- We came here because our family was living here and our ancestors were from here…we are living in our relatives' house and share the house with them…our family gave us a room, we want to return to our own place but until then we will stay with our family (woman).
- My family and I stay in the barracks that was built by NGOs, private organisations and government… many of the barracks were damaged because the barracks is already 3 years old and last month several barracks were hit by a hurricane, some of our family and friends who lived in the barracks were moved to our families and friends' barracks. The situation became more crowded (man).
- My family and I live in the family home, they provided us with a small house with a earth floor and separated from their main house (young woman).
- My family and I rent a house with 2 bed rooms, a living room and a kitchen…the house is fine for us before we return to our place in Sampit Kalimantan (man)
- We live in this barracks because is close to the *puskesmas* …compared to our families and friends who live in the woods (man). Yes it is to our benefit to stay here and then we are close to the public service areas such the market and shops (woman).
- Although we have to buy food in the market, at the moment food supplies are adequate and we eat three times a day and now we are self-supporting. The meals are composed of rice and corn with variety provided by meat, tofu and vegetables (man)

Q. How these conditions affect your health?

- Living in this barracks, we are vulnerable to suffer diseases. Several of my family members and friends were suffered by common cold and fever (man).
- We also suffer from stress problems. Our experiences in the conflict are very difficult to forget (woman).

Q. How do you cope if you have an illness?

- When my child became ill, we rushed him to the health facility, at that time the health facility was closed and we went to the health officer's house to ask for help (woman).
- I went to the *puskesmas* to get a treatment…I had to buy a Rp. 2,000 (15 pence) ticket and I got the health care from the health officer. I also heard that…if we want to have injection we have to pay for the syringe…I don't know how much it costs (woman).
- We have to take care of our mother who has had paralysis for 2 years … every month, we have to go to the *Puskesmas* for vitamins and drugs or purchase them in a local store, fortunately we live close to the *puskesmas* (man).

Q. What are the health services available in this area?
- Health programmes and services offered by the *puskesmas* is basic medical treatment and MCH also family planning (man).
- Yes… there is also an immunisation programme and an environmental health programme….the programmes are offered by the *puskesmas* (woman).
- Health programmes and services were also offered in the *posyandu* and near here there are 3 active *posyandu*s to provide MCH and immunisation services, sometimes we can ask the health officer for basic medical care (woman).
- Yes…we can also ask for an injection if we feel sick, but we have to pay for the syringe (man).
- Environment health programmes were also provided by the *puskesmas* and NGOs, but last year the NGOs stopped their programmes (woman).
- The *puskesmas*…came here to fog the barracks but that was last year (young man).

Q. What are your experiences to obtain health services in this area?
- I remember….the health programmes and services such as basic medical treatment, food and nutrition, water supply and toilets were also offered by NGOs and private organisations …unfortunately these programmes were terminated (man).
- Health promotion was also offered by the *puskesmas* but only every 5-6 months per year (woman).
- When my son broke his leg when he fell from a tree…we rushed him to the hospital in Sampang… we didn't pay for the ambulance because at that time one NGO help us to cover the expenses (man).

Q. How satisfied the health services offered by the public health sector?
- I was not pleased with treatment in this health facility in this area because the nurse didn't mention what kind of disease I was suffered (man)
- The drugs that I received were similar with one of my family's drugs, although we had a different symptom.
- Our situation is that when we don't have a job generating income, we just wait for outside help…we don't have enough money to go to the health facilities to control my pregnancy, we have to pay for transport and pay a fee for registration, even though the service is free, life here is very difficult (woman).

Q. How do you access the health services provided by public health sector?
- We don't have any problem in going to the health facilities either *puskesmas* or *posyandu* because we live near the health facilities (man).
- Yes…the doctors open their private clinics in the afternoon, but I have never gone there, we don't have enough money to pay for the doctor (woman).

Q. Is there any health project you know for this temporary?
- I don't know (man)
- We don't know (woman)

Q. How is the relationship and security in the temporary accommodation?
- We have a good relationship with the local people, even though sometimes we have had frictions such as the matter of the youngster issues where they more like to fight with the local youngsters (man)
- The security in this area is fine for us (man)

Q. What are your suggestions particularly for health services in this area?

- We live far from the hospital because the hospital is located in the capital city of this district, we need an free of charge ambulance to help us if we have a problem like my friend's case (man).
- We realised that living here is difficult; we want to return to our original places. Some of our friends are trying to go back to check our property with help from the NGOs (man)

3. Focus Group Discussion in Banyuates Sub-district

The focus group discussion conducted in the relatives' houses had seven participants: one informal leader of IDPs, one elderly person, two heads of households, one pregnant woman, one housewife and one young girl as group members.

Q. Tell how you and your family arrived in this camp?

- First we lived in the city in Java Island. My family and I moved here because we heard that there were facilities for IDPs supported by the government and NGOs (man).
- We moved here because our neighbours in our homeland who were already here gave us information that there were several barracks provided by the government, NGOs and private companies for IDPs. We needed to be with our friends here (man).
- Our household moved here because this is our ancestral homeland, and we think we will be safe living here temporarily (woman). We moved to this place because several of our families were living here (woman).

Q. Tell me how about the conditions of the accommodation in what you are now living?

- In this sub-district we stay in our friend's house. The house is very simple and tiny and there are 2 rooms, one bed room and one living room (man).
- My family and I live in the family house and the house had two bed rooms and living room. The house is located in the tobacco plantation we have to walk about 3 km to reach the main road (man)
- My family and I live in a friend's house. There are two bed rooms and the floor is earth (woman).
- I live in a tiny house that we bought 3 years ago when we arrived here from Sampit Central Kalimantan province. The house is close to the main road (man)
- I live with my parents in our family's house in the village near the tobacco plantation. The house is very small with an earth floor my brother and I sleep in the living room and because the floor is earth we use "the chop bamboo" for our bed (young girl).

Q. How these conditions affect your health?

- The condition of our temporary accommodation is potential to have diseases because is too crowed, my family consist of five member and we live only in one room(man).
- Yes, I agree with that man, we are becoming vulnerable to have diseases living in the temporary houses (woman)

Q. How do you cope if you have an illness?

- If we have an illness we buy a drug in the small store in this area, but if the illness were serious we would go to the *puskesmas* (woman).
- sometimes we just ignore the diseases because we don't have enough money to buy the drugs of we used traditional drugs such as a kind of plantation for fever (man).

Q. What are the health services available in this area?
- Nutrition, MCH, immunisation
- Family health programmes are also offered by the *puskesmas* (man).
Contraception methods are very easy to find in this area, but in order get the family planning service offered by the health facilities I had to pay Rp. 25,000 = £2 for the contraceptive method (woman).
- Water supply programmes came from the government and non-government organisations and improved the access to water by prepared wells for water drinking and washing in the temporary housing areas (woman)
- basic medical treatment in the *puskesmas* …(man)
- weighing our babies and sometimes our babies have a green bean meal provided by the *posyandu* (woman).

Q. What are your experiences to obtain health services in this area?
- When we first arrived in this area we received food, but there has been no food distribution from the government and WFP in the barracks since 2003 (man).
- We also got support from NGOs, they gave us milk, rice, biscuits, noodles for our food (woman).
- The health programmes and services offered by *puskesmas* are basic medical treatments and environmental health programmes. To get basic medical treatment we have to go to the *puskesmas* (man).
- There are several health programmes from *puskesmas* for us, family planning, MCH, immunisation, spraying the houses (woman).
- There are several programmes available in *posyandu* such as MCH (woman).
- Two months ago I suffered from illness and just bought the drugs in the store and I was felt well after 3 days (elderly).

- Immunisation programmes for the babies and children are conducted regularly by the *puskesmas* (woman).
- I agree with her, the immunisation programme for the infants is also free of charge. My baby had one just a couple weeks ago and it's free (woman).
I've never heard about environmental health programmes in this area (man).
- Yes… me neither, I never heard about environmental health programmes (woman). - I heard about the environmental health programmes dealing with a healthy environment as well eradicating the mosquitoes, but in our homeland not here (man).
- I've never heard of eradication of mosquitoes here (woman).
- I've heard of the environmental health programmes that deal with providing clean water and toilets (man).

Q. How satisfied the health services offered by the public health sector?
- We live in the forest area in this district and it makes life difficult for us because we are far from health facilities and other public facilities (man).
- I agree with him, we are living in a remote place and for us it is difficult to get access to health services. Yes, we have a regular health service from *puskesmas* who visit us each month, but when we have ill, the schedule of the mobile *puskesmas* is different. Illness doesn't recognise the time schedule of the *puskesmas* (laughter) (man).

Q. How do you access the health services provided by public health sector?
- We had a problem in terms of reaching the health facilities because they are far from our place (man).
- Yes, we have to cross the woods and paddy rice to reach the *puskesmas* (woman). - - We don't have enough money to pay the health services and for transportation because we have to take a small bus to the *puskesmas* (man).
- I have to pay Rp 2,000 (15 pence), and I have to use transportation to go there which costs Rp 5,000 for the return trip. I also had to pay the syringe that use for injection to the *puskesmas* Rp 2,000 (man).
- I think the government should think about us because of our situation, we don't have money to pay to control our health (woman)

- We sometimes use the health facilities if we feel our illness is severe (woman).
- We use the health facilities so we have the opportunity to have the doctor control our illness (woman)
- When I went to the *puskesmas*, the health officer gave me a simple treatment for the urine stones that I am suffering from and a letter referring me to the hospital, but I don't have enough money to go to the hospital (man)
- When I went to the *puskesmas* to get a treatment for my stomach, the *puskesmas* gave me tablets for my stomach and up to now I am still feeling sick. The nurse who gave me treatment only asked what I felt, and measured my blood pressure and gave me a drug without any further communication (man).
- I went to the *puskesmas* to get some drugs because I felt dizziness and I needed a drug to cure it (man).
- If I get a disease, I never go to the *puskesmas* to have treatment; I usually buy the drugs in the store near our place (man).
- When I had a problem with my left foot I went to the traditional healer to get oil for massage (man).
- The skills of the doctor in handling our health were good; however, the consultation was very short. It happened also with the nurses, they examined the patient too fast (woman).

Q. Is there any health project you know for this temporary?
- We don't know about the health project in this temporary area, we just know that there was a new *pustu* built by the local government, but there is no health service available (man).

Q. What are your suggestions particularly for health services in this area?

- We need regular health promotions such as eradication of communicable diseases especially malaria and dengue hemorrhagic fever through spraying; providing a system free of charge if the IDPs are getting ill and looking for health care delivery in the local health authorities' facilities either at *puskesmas* or hospital until we will return to our original places (man).

Q. How is the relationship and security in the temporary accommodation?
- We live far from the hospital because the hospital is located in the capital city of this district, we need an free of charge ambulance to help us if we have a problem like my friend's case (man).
- We realised that living here is difficult; we want to return to our original places. Some of our friends are trying to go back to check our property with help from the NGOs (man)

4. Focus Group Discussion in Robatal Sub-district

Q. Tell how you and your family arrived in this camp?
- we came to this place because many our family lived here and our ancestors were from here (man).
- We came to this place because…in the previous place we felt isolated from our family and friends and there was no special assistance from the government in the first place we escaped to, that is why we moved here (man).
- In this sub-district we are living in the family home but separated from our family's main house. The house is very simple and tiny with just one bed room and one living room. The house is about 1 km from main road; we have to walk in the bush and woods to reach the settlement (man).
- My family and I live in the family house and we have only one room for sleeping, we don't have a living room. The house is in the middle of woods, we have to walk about 2 km to reach the main road (woman)
- My family and I live in a friend's house with only one room for sleeping… we have to cook our meals outside of the house using an open fire. The house is about 500 meters from this place (man)
- I am also similar to my friend. My family and I live in the family house with only one room for sleeping and we don't have a living room, but the house is far from here about 2 km.
3 years ago when we arrived form Sampit Central Kalimantan province, I bought a house but just a tiny house. This house is close to the main road and easy for us to go to the health facility (man)
- I live with my parents in our family's house in the village near the paddy rice field. The house is very tiny with an earth floor…two of my sisters were slept in the living room using several board (young girl).

Q. Tell me how about the conditions of the accommodation in what you are now living?
- Most of people who live in this area suffer from several kinds of disease symptoms, particularly communicable diseases such as the common cold and coughs which are more frequent particularly in the wet seasons. In the dry season the incidence of skin diseases is more frequent (woman). Yes, one of my household suffered from fever and he is still ill (man).
- My daughter also suffered from a cold (woman). Two weeks ago my wife suffered from a cough because of the rainy weather (man).
- The location of our places is far from the water sources…we have to go to the river to wash our clothes. In the rainy season we use the rainwater that we keep in the rainwater reservoirs donated by the NGO (woman).
- Our place is also the same as my friend's, we are far from water resources…we have to collect the rainwater in the rainy season. If not we have to go to the river which is far from our place and sometimes the water is limited because of the dry season (man).
- Yes my family has similar problems as my two friends' because we live nearby (woman)
- When the first year we arrived in this area there has been food distribution from the government and WFP in the barracks but since 2003 the programme was terminated (woman).
- We were also got support from NGOs, noodles, milk, biscuits for our additional main staples (man).

Q. How these conditions affect your health?
- Living in this temporary accommodation makes us easy to have diseases because the room is too small (woman)

Q. How do you cope if you have an illness?
- Sometimes we just ignored the diseases because we don't have money to pay the transport to the puskesmas or we use traditional drugs.
- Several weeks ago month I had a stomach pain, I suffered for several days and I bought a drug in the store and took it for couple days to relief. But the illness is sometimes recurrent. Finally I decided to go to the *puskesmas* to get treatment and information about what kind of illness I was suffering from (woman).
- We use the health facilities if we feel our illness is starting to get bad (woman).

Q. What are the health services available in this area?
-The health programmes and services offered by *puskesmas* were MCH, family planning, immunisation, basic medical treatment and health environment. To get the basic medical treatment we have to go to the *puskesmas* (man).
- We can have the MCH programmes in the *posyandu* as well as counselling for family planning, but at the moment I do not need a contraceptive method because my husband is working outside of this area (woman).
- Several times over 3 months I went to the *puskesmas* to have treatment for my illness, but I still feel unwell (man).
- Last month I had a headache, I suffered for several days and I bought a drug in the store and took it for about 2 days, but I still suffered with those symptoms, finally I decided to go to the *puskesmas* to get treatment and information about what kind of illness I was suffering from (man).
- Immunisation programmes for the babies and children and pregnant woman was regularly conducted local health authority in *posyandu* and *puskesmas* (woman)
- Yes…..the programme is free of charge (woman).
- The environmental health programmes in this area offered by local health authority is providing water and toilets. I heard the environmental health programmes that also dealing with providing clean water and toilet, but many toilets were in poor condition (man).
- In last year there was a spraying programme from puskesmas (woman)
- We lived in the forest area in this district and the condition is not good to us because we have to walk several kilometres to reach the main road (man).
- I agree with him, we are living in the remote places and for us difficult to get access to health services, although there are mobile clinic from puskesmas visit this place once a week (man).

Q. What are your experiences to obtain health services in this area?
- The services was good but the drugs was similar with different symptoms
We also had a problem in terms of reaching the health facilities because the distance is about 10 km from our place (woman).
- Yes, we have to cross the tobacco plantation to get the *puskesmas* (man).
- Moreover, we don't have enough money to get the health services and we have to pay the transportation to the health centre and purchase the drugs (man).

Q. How satisfied the health services offered by the public health sector?
- When we go to *puskesmas* to check up our health…we have to pay Rp 2,000 (15 pence), and we also have to pay the transport Rp. 5,000 return. That's true, we live in a isolated place, we have to walk about 3 km sand finally we reach the main road to wait for the bus to take us to the *puskesmas* or other public facilities (man).
- If we had an injection, we had to pay the *puskesmas* in amount Rp 2,000 for the syringe woman).

- Yes we have to pay the costs for the health services and this is a great burden to us who have had bad experiences in their lives and lost their property and other things, we are poor (man).
- We use the health facilities to get drugs for our parent because they are old and sometimes there feeling unwell (woman).
- When I went to the *puskesmas* to have a treatment for my back pain, the *puskesmas* that gave me tablets and injection, the interview with the nurse is too short (woman). If I get a disease, I never go to the *puskesmas* to get treatment, I usually buy the drugs in the store in Ketapang shops (man).
- Yes… it was different with me; I went to the traditional healer to get the traditional drugs for my cold (woman). We don't have enough money to use the health services and we have to pay for transport to the health centre and purchase the drugs (man).

Q. How do you access the health services provided by public health sector?
- The skills of the paramedics were good; they handle the patients with professional capability. In addition, the availability of medical doctors in the health facilities is 24 hours a day, but in several *puskesmas* the doctors live in the town (man).
- I agree with him…but sometimes when the nurse gave me drugs, they were similar to the drugs of other patients who suffered from different diseases (woman).
- We need health education and promotion such as how we have to live health in this situation and we need a policy from local government to provide free health services to us that similar with the firs year we arrived here until we return to our homeland (man).
- We want to return to Sampit Kalimantan because we don't have any jobs here, our properties are still there although we do not know if they are still intact or not (man).
- Yes….life here is very difficult, especially as we have to compete with the local people to find jobs (man). Life here is difficult, particularly in the dry season (man).

Q. Is there any health project you know for this temporary?
- We don't know (man)

Q. How is the relationship and security in the temporary accommodation?
Sometime the youngsters had conflicts with local youngsters and make our relationship with local people here regrettable (man)

Q. What are your suggestions particularly for health services in this area?
Free of charge for health services (woman)

Appendix K: Table of Themes, Sub-themes, Categories and Typical Responses of Focus Group Discussions

No.	Themes	Sub-themes	Categories	Responses
1.	Reasons for flight to the recipient areas			*"…after the riots we came directly from North Maluku province to Manado City, because we thought this area was safe for us. We already lived in several places before we came to the temporary accommodation here in Mapanget Sub-district"* (Eldely male, Mapanget). *"…we came here because our family was living here and our ancestors were from here…we are living in our relatives' house and share the house with them…our family gave us a room, we want to return to our own place but until then we will stay with our family* (Adult female, Robatal).
2.	Characteristics of Temporary Accommodation Areas	Living Conditions of the IDPs		*"…we live in a very simple house with one bed room and one living room and the floor is made of cement here in Mapanget Sub-district* (Adult female, Mapanget) *"…the condition of our temporary accommodation has the potential to lead to diseases because it is too crowded, my family consists of five members and we are living in one room only* (Adult male, Banyuates).
		Water Supply and Sanitation	*Water Supply*	*"…to find water in this area is easy… we can take the clean water from the well and piped water. To wash our clothes we use water from the river"* (Adult female, Mapanget). *"…The location of our places is far from the water sources…we have to go to the river to wash our clothes. In the rainy season we use the rainwater that we keep in the rainwater reservoirs donated by the NGO*" (Adult female, Robatal).
			Sanitation	*"…garbage produced by IDP households is difficult to handle, we dug several pits for the garbage but the pits are already full and some of households just throw their garbage on the land surrounding their houses* (Adult male, Mapanget) *"…we don't use the latrine that the government and NGOs built for us because there is no water available and also we didn't feel comfortable using those latrines. We went to the bush surrounding the houses for defecating"* (Adult male, Robatal)

3.	Health Problems Experienced by IDPs			*"…living in this area, we also suffer from diseases. Certain types of disease symptoms such as muscle pain, malaria, cold and coughs, are common particularly in the wet seasons* (Elderly male, Mapanget). *"...most of people who live in this area suffer from several kinds of disease symptoms, particularly colds and coughs which are common particularly during the wet seasons. Being stressed is also one of our problems because of our past experiences and living in this place. In the dry season the occurrence of skin diseases is common* (Adult female, Robatal*).*
4.	IDP Health Care Decisions for Coping with Health Problems			*"…sometimes we just ignore the diseases because we don't have enough money to buy the drugs"* (Adult male, Mapanget). *"…if we have an illness we buy a drug in the small store in this area, but if the illness were serious we would go to the puskesmas"* (Adult female, Banyuates*).*
5.	The IDPs' Experiences with Health Services	The Availability of Health Services		*"…the health programmes and services that available in this area as I remember are MCH, family planning and immunization" (*Adult male, Mapanget*).* *"…the puskesmas officers…came here for the mosquito fogging programme to fog the barracks but that was last year (*Young male, Ketapang).
		Utilisation of Health Facilities		*"…we almost always used the health post (posyandu). We were using the health facility for pregnant women and the immunisation programme that was conducted by the puskesmas which ran a posyandu regularly in the church building in this compound area* (Adult female, Mapanget). *"…the services offered by puskesmas are basic medical treatments. To obtain basic medical treatment we have to go to the puskesmas particularly if we suffered from severe illness"* (Adult male, Banyuates).
		Key Barriers to Accessing Health Facilities	*Economic barriers*	*"…to get family planning service offered by health facilities in this area was very easy for me, but I had to pay Rp. 25,000 = £2 for the contraceptive method and it is expensive for me"* (Adult female, Mapanget)

				"…we don't have enough money to get the health services and we have to pay the transportation to the health centre and purchase the drugs" (Adult male, Robatal).
			Distance barrier	*"…the locations of health facilities are too far from our place and we need transportation to go there"* (Adult female, Mapanget). *"…we are living in a remote place and for us it is difficult to get access to health services. Yes, we have a regular health service from puskesmas who visit us every month, but when we have illness, the schedule of the mobile puskesmas is different. Illness doesn't recognise the time schedule of the puskesmas (laughter)"* (Adult male, Banyuates).
			Cultural barrier	*"…we believe that an infant under six months old should never be injected"* (Adult female, Mapanget). *"…I preferred to deliver my baby in my house; it was more convenient because I felt comfortable compared to being in the puskesmas. I just felt uncomfortable about delivering in the puskesmas. I delivered my baby with the TBA's help and the delivery process was safe, the baby was fine"* (Adult female, Mapanget).
		Satisfaction with Health Services		*"…I was not satisfied with treatment in the puskesmas. I needed more information about the illness from which I suffered so much" (*Adult female, Mapanget). *"…several times over 3 months I went to the puskesmas to have treatment for my illness, but I still feel unwell* (Adult male, Robatal).
6.	Other Issues Related to Health of IDPs	Food Security		*"…when we first arrived in this area we received food, but there has been no food distribution from the government and World Food Programme (WFP) in the barracks since 2003* (Adult male, Mapanget). *"…the first year we arrived in this area there was food distribution from the government and WFP in the barracks but in 2003 the service was terminated* (Adult female, Robatal).
		Security and Social Interaction with Local Community		*"…sometimes the young men have clashed, but in general we have a good relationship with the people here* (Elderly male, Mapanget). *"…the security in this area is fine for us, but we worry because sometimes there has been fighting between young IDP men and the local young men block the road to the market and other public facilities"* (Young male, Banyuates).